

ASSEMBLY BILL

No. 1083

**Introduced by Assembly Member Monning
(Principal coauthor: Assembly Member Feuer)**

February 18, 2011

An act to amend Sections 1357, 1357.03, 1357.05, 1357.06, 1357.07, 1357.12, and 1357.14 of, to amend, repeal, and add Sections 1357.15, 1357.50, 1357.51, and 1357.52 of, and to add Section 1357.18 to, the Health and Safety Code, and to amend Sections 10700, 10705, 10706, 10707, 10708, 10709, 10714, and 10716 of, to amend, repeal, and add Sections 10198.6, 10198.7, 10198.9, and 10717 of, and to add Section 10718.8 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1083, as introduced, Monning. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, imposes various requirements, some of which take effect on January 1, 2014, on states, health plans, employers, and individuals regarding health care coverage. Pursuant to the requirements of that act, existing state law establishes the California Health Benefit Exchange for the purpose of, among other things, making available qualified health plans to qualified individuals and employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health carriers by the Department of Insurance. Existing law provides for the regulation of health care service plans and health carriers that offer plan contracts or health benefit plans, respectively, to small employers with regard to

eligible employees, as defined. Existing law prohibits a plan or solicitor or a carrier or agent or broker from encouraging or directing small employers to seek coverage from another plan or carrier or the Voluntary Alliance Uniting Employers Purchasing Program. Existing law also regulates provisions related to preexisting conditions and late enrollees, as defined.

For purposes of that coverage, this bill would change the definitions and criteria related to eligible employees and rating periods, and, on and after January 1, 2014, risk adjustment factors, age categories, health status-related factors, and small employers, as specified. The bill would require employer contribution requirements to be consistent with the federal Patient Protection and Affordable Care Act. With regard to the sale of plan contracts or health benefit plans, the bill would prohibit specified persons or entities from encouraging or directing small employers to seek coverage from another plan or the voluntary purchasing pool established under the California Health Benefit Exchange. The bill would prohibit certain contracts between plans and solicitors, or between carriers and agents or brokers, with regard to the California Health Benefit Exchange. The bill would make other conforming changes to implement the federal act with regard to preexisting conditions, to become effective January 1, 2014, and would make other changes to preexisting condition provisions, notices, and provisions related to late enrollees. The bill would also impose certain limitations on wellness programs if offered by a plan or carrier to small employers pursuant to a health care service plan contract or health benefit plan, as specified, and would require those wellness programs to be approved by the Department of Managed Health Care or the Department of Insurance, respectively.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1357 of the Health and Safety Code is amended to read:

1357. As used in this article:

(a) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) “Eligible employee” means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of ~~at least~~ *an average of 30 hours over the course of a month*, at the small employer’s regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least ~~20~~ 10 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least ~~20~~ 10 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period

1 in question, including, but not limited to, payroll records and
2 employee wage and tax filings.

3 (2) Any member of a guaranteed association as defined in
4 subdivision (o).

5 (c) “In force business” means an existing health benefit plan
6 contract issued by the plan to a small employer.

7 (d) “Late enrollee” means an eligible employee or dependent
8 who has declined enrollment in a health benefit plan offered by a
9 small employer at the time of the initial enrollment period provided
10 under the terms of the health benefit plan and who subsequently
11 requests enrollment in a health benefit plan of that small employer,
12 provided that the initial enrollment period shall be a period of at
13 least 30 days. It also means any member of an association that is
14 a guaranteed association as well as any other person eligible to
15 purchase through the guaranteed association when that person has
16 failed to purchase coverage during the initial enrollment period
17 provided under the terms of the guaranteed association’s plan
18 contract and who subsequently requests enrollment in the plan,
19 provided that the initial enrollment period shall be a period of at
20 least 30 days. However, an eligible employee, any other person
21 eligible for coverage through a guaranteed association pursuant to
22 subdivision (o), or an eligible dependent shall not be considered
23 a late enrollee if any of the following is applicable:

24 (1) The individual meets all of the following requirements:

25 (A) He or she was covered under another employer health
26 benefit plan, the Healthy Families Program, the Access for Infants
27 and Mothers (AIM) Program, ~~or~~ the Medi-Cal program, *or the*
28 *California Health Benefit Exchange* at the time the individual was
29 eligible to enroll.

30 (B) He or she certified at the time of the initial enrollment that
31 coverage under another employer health benefit plan, the Healthy
32 Families Program, the AIM Program, ~~or~~ the Medi-Cal program,
33 *or the California Health Benefit Exchange* was the reason for
34 declining enrollment, provided that, if the individual was covered
35 under another employer health plan, the individual was given the
36 opportunity to make the certification required by this subdivision
37 and was notified that failure to do so could result in later treatment
38 as a late enrollee.

39 (C) He or she has lost or will lose coverage under another
40 employer health benefit plan as a result of termination of

1 employment of the individual or of a person through whom the
2 individual was covered as a dependent, change in employment
3 status of the individual or of a person through whom the individual
4 was covered as a dependent, termination of the other plan's
5 coverage, cessation of an employer's contribution toward an
6 employee or dependent's coverage, death of the person through
7 whom the individual was covered as a dependent, legal separation,
8 or divorce; or he or she has lost or will lose coverage under the
9 Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal
10 program, *or the California Health Benefit Exchange*.

11 (D) He or she requests enrollment within 30 days after
12 termination of coverage or employer contribution toward coverage
13 provided under another employer health benefit plan, or requests
14 enrollment within 60 days after termination of Medi-Cal program
15 coverage, AIM Program coverage, ~~or~~ Healthy Families Program
16 coverage, *or coverage through the California Health Benefit*
17 *Exchange*.

18 (2) The employer offers multiple health benefit plans and the
19 employee elects a different plan during an open enrollment period.

20 (3) A court has ordered that coverage be provided for a spouse
21 or minor child under a covered employee's health benefit plan.

22 (4) (A) In the case of an eligible employee, as defined in
23 paragraph (1) of subdivision (b), the plan cannot produce a written
24 statement from the employer stating that the individual or the
25 person through whom the individual was eligible to be covered as
26 a dependent, prior to declining coverage, was provided with, and
27 signed, acknowledgment of an explicit written notice in boldface
28 type specifying that failure to elect coverage during the initial
29 enrollment period permits the plan to impose, at the time of the
30 individual's later decision to elect coverage, an exclusion from
31 coverage for a period of 12 months as well as a six-month
32 preexisting condition exclusion, unless the individual meets the
33 criteria specified in paragraph (1), (2), or (3).

34 (B) In the case of an association member who did not purchase
35 coverage through a guaranteed association, the plan cannot produce
36 a written statement from the association stating that the association
37 sent a written notice in boldface type to all potentially eligible
38 association members at their last known address prior to the initial
39 enrollment period informing members that failure to elect coverage
40 during the initial enrollment period permits the plan to impose, at

1 the time of the member's later decision to elect coverage, an
2 exclusion from coverage for a period of 12 months as well as a
3 six-month preexisting condition exclusion unless the member can
4 demonstrate that he or she meets the requirements of subparagraphs
5 (A), (C), and (D) of paragraph (1) or meets the requirements of
6 paragraph (2) or (3).

7 (C) In the case of an employer or person who is not a member
8 of an association, was eligible to purchase coverage through a
9 guaranteed association, and did not do so, and would not be eligible
10 to purchase guaranteed coverage unless purchased through a
11 guaranteed association, the employer or person can demonstrate
12 that he or she meets the requirements of subparagraphs (A), (C),
13 and (D) of paragraph (1), or meets the requirements of paragraph
14 (2) or (3), or that he or she recently had a change in status that
15 would make him or her eligible and that application for enrollment
16 was made within 30 days of the change.

17 (5) The individual is an employee or dependent who meets the
18 criteria described in paragraph (1) and was under a COBRA
19 continuation provision and the coverage under that provision has
20 been exhausted. For purposes of this section, the definition of
21 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
22 apply.

23 (6) The individual is a dependent of an enrolled eligible
24 employee who has lost or will lose his or her coverage under the
25 Healthy Families Program, the AIM Program, ~~or the Medi-Cal~~
26 program, *or the California Health Benefit Exchange*, and requests
27 enrollment within 60 days after termination of that coverage.

28 (7) The individual is an eligible employee who previously
29 declined coverage under an employer health benefit plan and who
30 has subsequently acquired a dependent who would be eligible for
31 coverage as a dependent of the employee through marriage, birth,
32 adoption, or placement for adoption, and who enrolls for coverage
33 under that employer health benefit plan on his or her behalf and
34 on behalf of his or her dependent within 30 days following the
35 date of marriage, birth, adoption, or placement for adoption, in
36 which case the effective date of coverage shall be the first day of
37 the month following the date the completed request for enrollment
38 is received in the case of marriage, or the date of birth, or the date
39 of adoption or placement for adoption, whichever applies. Notice
40 of the special enrollment rights contained in this paragraph shall

1 be provided by the employer to an employee at or before the time
2 the employee is offered an opportunity to enroll in plan coverage.

3 (8) The individual is an eligible employee who has declined
4 coverage for himself or herself or his or her dependents during a
5 previous enrollment period because his or her dependents were
6 covered by another employer health benefit plan at the time of the
7 previous enrollment period. That individual may enroll himself or
8 herself or his or her dependents for plan coverage during a special
9 open enrollment opportunity if his or her dependents have lost or
10 will lose coverage under that other employer health benefit plan.
11 The special open enrollment opportunity shall be requested by the
12 employee not more than 30 days after the date that the other health
13 coverage is exhausted or terminated. Upon enrollment, coverage
14 shall be effective not later than the first day of the first calendar
15 month beginning after the date the request for enrollment is
16 received. Notice of the special enrollment rights contained in this
17 paragraph shall be provided by the employer to an employee at or
18 before the time the employee is offered an opportunity to enroll
19 in plan coverage.

20 (e) “New business” means a health care service plan contract
21 issued to a small employer that is not the plan’s in force business.

22 (f) ~~“Preexisting”~~ *Until January 1, 2014, “preexisting* condition
23 *provision” means a contract provision that excludes coverage for*
24 *charges or expenses incurred during a specified period following*
25 *the employee’s effective date of coverage, as to a condition for*
26 *which medical advice, diagnosis, care, or treatment was*
27 *recommended or received during a specified period immediately*
28 *preceding the effective date of coverage. On or after January 1,*
29 *2014, “preexisting condition” means, with respect to coverage, a*
30 *prohibited limitation or exclusion based on the fact that the*
31 *condition was present before the date of enrollment of the*
32 *coverage, whether or not any medical advice, diagnosis, care, or*
33 *treatment was recommended or received before that date.*

34 (g) “Creditable coverage” means:

35 (1) Any individual or group policy, contract, or program that is
36 written or administered by a disability insurer, health care service
37 plan, fraternal benefits society, self-insured employer plan, or any
38 other entity, in this state or elsewhere, and that arranges or provides
39 medical, hospital, and surgical coverage not designed to supplement
40 other private or governmental plans. The term includes continuation

1 or conversion coverage but does not include accident only, credit,
2 coverage for onsite medical clinics, disability income, Medicare
3 supplement, long-term care, dental, vision, coverage issued as a
4 supplement to liability insurance, insurance arising out of a
5 workers' compensation or similar law, automobile medical payment
6 insurance, or insurance under which benefits are payable with or
7 without regard to fault and that is statutorily required to be
8 contained in any liability insurance policy or equivalent
9 self-insurance.

10 (2) The Medicare Program pursuant to Title XVIII of the federal
11 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

12 (3) The Medicaid Program pursuant to Title XIX of the federal
13 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

14 (4) Any other publicly sponsored program, provided in this state
15 or elsewhere, of medical, hospital, and surgical care.

16 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
17 (Civilian Health and Medical Program of the Uniformed Services
18 (CHAMPUS)).

19 (6) A medical care program of the Indian Health Service or of
20 a tribal organization.

21 (7) A state health benefits risk pool.

22 (8) A health plan offered under 5 U.S.C. Chapter 89
23 (commencing with Section 8901) (Federal Employees Health
24 Benefits Program (FEHBP)).

25 (9) A public health plan as defined in federal regulations
26 authorized by Section 2701(c)(1)(I) of the Public Health Service
27 Act, as amended by Public Law 104-191, the Health Insurance
28 Portability and Accountability Act of 1996.

29 (10) A health benefit plan under Section 5(e) of the Peace Corps
30 Act (22 U.S.C. Sec. 2504(e)).

31 (11) Any other creditable coverage as defined by subdivision
32 (c) of Section 2701 of Title XXVII of the federal Public Health
33 ~~Services Service~~ Act (42 U.S.C. Sec. 300gg(c)).

34 (h) "Rating period" means the period for which premium rates
35 established by a plan are in effect and shall be no less than ~~six~~ 12
36 months.

37 (i) "Risk adjusted employee risk rate" means the rate determined
38 for an eligible employee of a small employer in a particular risk
39 category after applying the risk adjustment factor.

(j) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. *Effective January 1, 2014, the risk adjustment factor shall be zero.*

(k) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.). *Effective January 1, 2014, the rate for age shall not vary by more than three to one for adults.*

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be

1 deemed to be operating statewide if their coverage area includes
2 90 percent or more of the state's population. Geographic regions
3 established pursuant to this section shall, as a group, cover the
4 entire state, and the area encompassed in a geographic region shall
5 be separate and distinct from areas encompassed in other
6 geographic regions. Geographic regions may be noncontiguous.

7 (B) (i) In determining rates for small employers, a plan that
8 does not operate statewide shall use no more than the number of
9 geographic regions in the state that is determined by the following
10 formula: the population, as determined in the last federal census,
11 of all counties that are included in their entirety in a plan's service
12 area divided by the total population of the state, as determined in
13 the last federal census, multiplied by nine. The resulting number
14 shall be rounded to the nearest whole integer. No region may be
15 smaller than an area in which the first three digits of all its ZIP
16 Codes are in common within a county and no county may be
17 divided into more than two regions. The area encompassed in a
18 geographic region shall be separate and distinct from areas
19 encompassed in other geographic regions. Geographic regions
20 may be noncontiguous. No plan shall have less than one geographic
21 area.

22 (ii) If the formula in clause (i) results in a plan that operates in
23 more than one county having only one geographic region, then the
24 formula in clause (i) shall not apply and the plan may have two
25 geographic regions, provided that no county is divided into more
26 than one region.

27 Nothing in this section shall be construed to require a plan to
28 establish a new service area or to offer health coverage on a
29 statewide basis, outside of the plan's existing service area.

30 (l) "Small employer" means ~~either~~ any of the following:

31 (1) ~~Any~~ *Until January 1, 2014, any* person, firm, proprietary or
32 nonprofit corporation, partnership, public agency, or association
33 that is actively engaged in business or service, that, on at least 50
34 percent of its working days during the preceding calendar quarter
35 or preceding calendar year, employed at least two, but no more
36 than 50, eligible employees, the majority of whom were employed
37 within this state, that was not formed primarily for purposes of
38 buying health care service plan contracts, and in which a bona fide
39 employer-employee relationship exists. *On or after January 1,*
40 *2014, any person, firm, proprietary or nonprofit corporation,*

partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. ~~However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter.~~ In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(3) *On or after January 1, 2014, a self-employed individual who obtains at least 50 percent of annual income from self-employment as demonstrated through personal income tax filings for the current or prior year. To the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law, a self-employed individual whose modified annual gross income is anticipated to be less than 400 percent of the federal poverty level may at his or her discretion seek to enroll as an individual*

1 *rather than a small employer through the California Health Benefit*
2 *Exchange.*

3 (m) “Standard employee risk rate” means the rate applicable to
4 an eligible employee in a particular risk category in a small
5 employer group.

6 (n) “Guaranteed association” means a nonprofit organization
7 comprised of a group of individuals or employers who associate
8 based solely on participation in a specified profession or industry,
9 accepting for membership any individual or employer meeting its
10 membership criteria, and that (1) includes one or more small
11 employers as defined in paragraph (1) of subdivision (l), (2) does
12 not condition membership directly or indirectly on the health or
13 claims history of any person, (3) uses membership dues solely for
14 and in consideration of the membership and membership benefits,
15 except that the amount of the dues shall not depend on whether
16 the member applies for or purchases insurance offered to the
17 association, (4) is organized and maintained in good faith for
18 purposes unrelated to insurance, (5) has been in active existence
19 on January 1, 1992, and for at least five years prior to that date,
20 (6) has included health insurance as a membership benefit for at
21 least five years prior to January 1, 1992, (7) has a constitution and
22 bylaws, or other analogous governing documents that provide for
23 election of the governing board of the association by its members,
24 (8) offers any plan contract that is purchased to all individual
25 members and employer members in this state, (9) includes any
26 member choosing to enroll in the plan contracts offered to the
27 association provided that the member has agreed to make the
28 required premium payments, and (10) covers at least 1,000 persons
29 with the health care service plan with which it contracts. The
30 requirement of 1,000 persons may be met if component chapters
31 of a statewide association contracting separately with the same
32 carrier cover at least 1,000 persons in the aggregate.

33 This subdivision applies regardless of whether a contract issued
34 by a plan is with an association, or a trust formed for or sponsored
35 by an association, to administer benefits for association members.

36 For purposes of this subdivision, an association formed by a
37 merger of two or more associations after January 1, 1992, and
38 otherwise meeting the criteria of this subdivision shall be deemed
39 to have been in active existence on January 1, 1992, if its
40 predecessor organizations had been in active existence on January

1 1, 1992, and for at least five years prior to that date and otherwise
2 met the criteria of this subdivision.

3 (o) “Members of a guaranteed association” means any individual
4 or employer meeting the association’s membership criteria if that
5 person is a member of the association and chooses to purchase
6 health coverage through the association. At the association’s
7 discretion, it also may include employees of association members,
8 association staff, retired members, retired employees of members,
9 and surviving spouses and dependents of deceased members.
10 However, if an association chooses to include these persons as
11 members of the guaranteed association, the association shall make
12 that election in advance of purchasing a plan contract. Health care
13 service plans may require an association to adhere to the
14 membership composition it selects for up to 12 months.

15 (p) “Affiliation period” means a period that, under the terms of
16 the health care service plan contract, must expire before health
17 care services under the contract become effective.

18 (q) *“Wellness incentive” or “wellness program” means a*
19 *program of health promotion or disease prevention that is designed*
20 *to promote health or prevent disease and that meets the standards*
21 *of Section 1357.18.*

22 SEC. 2. Section 1357.03 of the Health and Safety Code is
23 amended to read:

24 1357.03. (a) (1) Upon the effective date of this article, a plan
25 shall fairly and affirmatively offer, market, and sell all of the plan’s
26 health care service plan contracts that are sold to small employers
27 or to associations that include small employers to all small
28 employers in each service area in which the plan provides or
29 arranges for the provision of health care services.

30 (2) Each plan shall make available to each small employer all
31 small employer health care service plan contracts that the plan
32 offers and sells to small employers or to associations that include
33 small employers in this state.

34 (3) No plan or solicitor shall induce or otherwise encourage a
35 small employer to separate or otherwise exclude an eligible
36 employee from a health care service plan contract that is provided
37 in connection with the employee’s employment or membership in
38 a guaranteed association.

39 (4) A plan contracting to participate in the voluntary purchasing
40 pool for small employers ~~provided for under Article 4~~

~~(commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code offered through the California Health Benefit Exchange shall be deemed in compliance with the requirements of paragraph (1) for a contract offered through the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code California Health Benefit Exchange in those geographic regions in which plans participate in the pool, if the contract is offered exclusively through the pool the California Health Benefit Exchange.~~

(5) (A) A plan shall be deemed to meet the requirements of paragraphs (1) and (2) with respect to a plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA if all of the following requirements are met:

(i) The plan offers to renew the plan contract, unless the plan withdraws the plan contract from the small employer market pursuant to subdivision (e) of Section 1357.11.

(ii) The plan provides appropriate notice of the grandfathered status of the contract in any materials provided to an enrollee of the contract describing the benefits provided under the contract, as required under PPACA.

(iii) The plan makes no changes to the benefits covered under the plan contract other than those required by a state or federal law, regulation, rule, or guidance and those permitted to be made to a grandfathered health plan under PPACA.

(B) For purposes of this paragraph, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder. For purposes of this paragraph, a “grandfathered health plan” shall have the meaning set forth in Section 1251 of PPACA.

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee’s premium. Employer

1 contribution requirements shall not vary by employer size.
2 *Employer contribution requirements shall be consistent with the*
3 *federal Patient Protection and Affordable Care Act (Public Law*
4 *111-148).* A health care service plan shall not establish a
5 participation requirement that (1) requires a person who meets the
6 definition of a dependent in subdivision (a) of Section 1357 to
7 enroll as a dependent if he or she is otherwise eligible for coverage
8 and wishes to enroll as an eligible employee and (2) allows a plan
9 to reject an otherwise eligible small employer because of the
10 number of persons that waive coverage due to coverage through
11 another employer. Members of an association eligible for health
12 coverage under subdivision (o) of Section 1357, but not electing
13 any health coverage through the association, shall not be counted
14 as eligible employees for purposes of determining whether the
15 guaranteed association meets a plan's reasonable participation
16 standards.

17 (c) The plan shall not reject an application from a small
18 employer for a health care service plan contract if all of the
19 following are met:

20 (1) The small employer, as defined by paragraph (1) of
21 subdivision (l) of Section 1357, offers health benefits to 100
22 percent of its eligible employees, as defined by paragraph (1) of
23 subdivision (b) of Section 1357. Employees who waive coverage
24 on the grounds that they have other group coverage shall not be
25 counted as eligible employees.

26 (2) The small employer agrees to make the required premium
27 payments.

28 (3) The small employer agrees to inform the small employers'
29 employees of the availability of coverage and the provision that
30 those not electing coverage must wait one year to obtain coverage
31 through the group if they later decide they would like to have
32 coverage.

33 (4) The employees and their dependents who are to be covered
34 by the plan contract work or reside in the service area in which
35 the plan provides or otherwise arranges for the provision of health
36 care services.

37 (d) No plan or solicitor shall, directly or indirectly, engage in
38 the following activities:

39 (1) Encourage or direct small employers to refrain from filing
40 an application for coverage with a plan because of the health status,

1 claims experience, industry, occupation of the small employer, or
2 geographic location provided that it is within the plan's approved
3 service area.

4 (2) Encourage or direct small employers to seek coverage from
5 another plan or the voluntary purchasing pool established under
6 ~~Article 4 (commencing with Section 10730) of Chapter 8 of Part~~
7 ~~2 of Division 2 of the Insurance Code~~ *the California Health Benefit*
8 *Exchange* because of the health status, claims experience, industry,
9 occupation of the small employer, or geographic location provided
10 that it is within the plan's approved service area.

11 (e) (1) A plan shall not, directly or indirectly, enter into any
12 contract, agreement, or arrangement with a solicitor that provides
13 for or results in the compensation paid to a solicitor for the sale of
14 a health care service plan contract to be varied because of the health
15 status, claims experience, industry, occupation, or geographic
16 location of the small employer. This subdivision does not apply
17 to a compensation arrangement that provides compensation to a
18 solicitor on the basis of percentage of premium, provided that the
19 percentage shall not vary because of the health status, claims
20 experience, industry, occupation, or geographic area of the small
21 employer.

22 (2) *Effective January 1, 2014, a plan shall not, directly or*
23 *indirectly, enter into any contract, agreement, or arrangement*
24 *with a solicitor that provides for or results in the compensation*
25 *paid to a solicitor for the sale of a health care service plan contract*
26 *to be varied based on whether the small employer obtains coverage*
27 *through the California Health Benefit Exchange or directly from*
28 *the health care service plan.*

29 (f) A policy or contract that covers ~~two~~ *one* or more employees
30 shall not establish rules for eligibility, including continued
31 eligibility, of an individual, or dependent of an individual, to enroll
32 under the terms of the plan based on any of the following health
33 status-related factors:

- 34 (1) Health status.
- 35 (2) Medical condition, including physical and mental illnesses.
- 36 (3) Claims experience.
- 37 (4) Receipt of health care.
- 38 (5) Medical history.
- 39 (6) Genetic information.

1 (7) Evidence of insurability, including conditions arising out of
2 acts of domestic violence.

3 (8) Disability.

4 (9) *Any other health status-related factor as determined by the*
5 *department.*

6 (g) A plan shall comply with the requirements of Section 1374.3.

7 SEC. 3. Section 1357.05 of the Health and Safety Code is
8 amended to read:

9 1357.05. ~~Except~~ *(a) Until January 1, 2014, except* in the case
10 of a late enrollee, or for satisfaction of a preexisting condition
11 clause in the case of initial coverage of an eligible employee, a
12 plan may not exclude any eligible employee or dependent who
13 would otherwise be entitled to health care services on the basis of
14 an actual or expected health condition of that employee or
15 dependent. No plan contract may limit or exclude coverage for a
16 specific eligible employee or dependent by type of illness,
17 treatment, medical condition, or accident, except for preexisting
18 conditions as permitted by Section 1357.06.

19 *(b) On or after January 1, 2014, a plan may not exclude any*
20 *eligible employee or dependent who would otherwise be entitled*
21 *to health care services on the basis of an actual or expected health*
22 *condition of that employee or dependent. No plan contract may*
23 *limit or exclude coverage for a specific eligible employee or*
24 *dependent by type of illness, treatment, medical condition, or*
25 *accident, except for preexisting conditions as permitted by Section*
26 *1357.06.*

27 SEC. 4. Section 1357.06 of the Health and Safety Code is
28 amended to read:

29 1357.06. (a) (1) ~~Preexisting~~ *Until January 1, 2014, preexisting*
30 condition provisions of a plan contract shall not exclude coverage
31 for a period beyond six months following the individual's effective
32 date of coverage and may only relate to conditions for which
33 medical advice, diagnosis, care, or treatment, including prescription
34 drugs, was recommended or received from a licensed health
35 practitioner during the six months immediately preceding the
36 effective date of coverage.

37 (2) Notwithstanding paragraph (1), a plan contract offered to a
38 small employer shall not impose any preexisting condition
39 provision upon any child under 19 years of age.

1 (3) *On or after January 1, 2014, preexisting condition provisions*
2 *of a plan contract shall not exclude coverage following the*
3 *individual's effective date of coverage for a condition based on*
4 *the fact that the condition was present before the date of enrollment*
5 *of the coverage, whether or not any medical advice, diagnosis,*
6 *care, or treatment was recommended or received before that date.*

7 (b) ~~A(1)~~ *Until January 1, 2014, a plan that does not utilize a*
8 *preexisting condition provision may impose a waiting or affiliation*
9 *period, not to exceed 60 days, before the coverage issued subject*
10 *to this article shall become effective. During the waiting or*
11 *affiliation period no premiums shall be charged to the enrollee or*
12 *the subscriber.*

13 (2) *On or after January 1, 2014, no waiting or affiliation period*
14 *shall be imposed.*

15 (c) ~~In~~ *Until January 1, 2014, in determining whether a*
16 *preexisting condition provision or a waiting or affiliation period*
17 *applies to any person, a plan shall credit the time the person was*
18 *covered under creditable coverage, provided the person becomes*
19 *eligible for coverage under the succeeding plan contract within 62*
20 *days of termination of prior coverage, exclusive of any waiting or*
21 *affiliation period, and applies for coverage with the succeeding*
22 *plan contract within the applicable enrollment period. A plan shall*
23 *also credit any time an eligible employee must wait before enrolling*
24 *in the plan, including any affiliation or employer-imposed waiting*
25 *or affiliation period. However, if a person's employment has ended,*
26 *the availability of health coverage offered through employment*
27 *or sponsored by an employer has terminated, or an employer's*
28 *contribution toward health coverage has terminated, a plan shall*
29 *credit the time the person was covered under creditable coverage*
30 *if the person becomes eligible for health coverage offered through*
31 *employment or sponsored by an employer within 180 days,*
32 *exclusive of any waiting or affiliation period, and applies for*
33 *coverage under the succeeding plan contract within the applicable*
34 *enrollment period.*

35 (d) ~~In~~ *Until January 1, 2014, in addition to the preexisting*
36 *condition exclusions authorized by subdivision (a) and the waiting*
37 *or affiliation period authorized by subdivision (b), health plans*
38 *providing coverage to a guaranteed association may impose on*
39 *employers or individuals purchasing coverage who would not be*
40 *eligible for guaranteed coverage if they were not purchasing*

1 through the association a waiting or affiliation period, not to exceed
2 60 days, before the coverage issued subject to this article shall
3 become effective. During the waiting or affiliation period, no
4 premiums shall be charged to the enrollee or the subscriber.

5 (e) An individual's period of creditable coverage shall be
6 certified pursuant to subdivision (e) of Section 2701 of Title XXVII
7 of the federal Public Health-~~Services~~ *Service* Act (42 U.S.C. Sec.
8 300gg(e)).

9 (f) A health care service plan issuing group coverage may not
10 impose a preexisting condition exclusion to a condition relating
11 to benefits for pregnancy or maternity care.

12 SEC. 5. Section 1357.07 of the Health and Safety Code is
13 amended to read:

14 1357.07. ~~No~~ *(a) Until January 1, 2014, no plan contract may*
15 *exclude late enrollees from coverage for more than 12 months*
16 *from the date of the late enrollees application for coverage. No*
17 *premium shall be charged to the late enrollee until the exclusion*
18 *period has ended.*

19 *(b) On or after January 1, 2014, no plan contract may exclude*
20 *a late enrollee from coverage for more than 90 days from the date*
21 *of the late enrollee's application for coverage. No premium shall*
22 *be charged to the late enrollee until the exclusion period has ended.*

23 SEC. 6. Section 1357.12 of the Health and Safety Code is
24 amended to read:

25 1357.12. Premiums for contracts offered or delivered by plans
26 on or after the effective date of this article shall be subject to the
27 following requirements:

28 (a) (1) The premium for new business shall be determined for
29 an eligible employee in a particular risk category after applying a
30 risk adjustment factor to the plan's standard employee risk rates.
31 The risk adjusted employee risk rate may not be more than 120
32 percent or less than 80 percent of the plan's applicable standard
33 employee risk rate until July 1, 1996. Effective July 1, 1996, this
34 factor may not be more than 110 percent or less than 90 percent.
35 *Effective January 1, 2014, the risk adjustment factor shall be zero.*

36 (2) The premium charged a small employer for new business
37 shall be equal to the sum of the risk adjusted employee risk rates.

38 (3) The standard employee risk rates applied to a small employer
39 for new business shall be in effect for no less than ~~six~~ 12 months.

1 (b) (1) The premium for in force business shall be determined
2 for an eligible employee in a particular risk category after applying
3 a risk adjustment factor to the plan's standard employee risk rates.
4 The risk adjusted employee risk rates may not be more than 120
5 percent or less than 80 percent of the plan's applicable standard
6 employee risk rate until July 1, 1996. Effective July 1, 1996, this
7 factor may not be more than 110 percent or less than 90 percent.
8 The factor effective July 1, 1996, shall apply to in force business
9 at the earlier of either the time of renewal or July 1, 1997. ~~The~~
10 *Until January 1, 2014, the risk adjustment factor applied to a small*
11 *employer may not increase by more than 10 percentage points*
12 *from the risk adjustment factor applied in the prior rating period.*
13 *Effective January 1, 2014, the risk adjustment factor shall be zero.*
14 The risk adjustment factor for a small employer may not be
15 modified more frequently than every 12 months.

16 (2) The premium charged a small employer for in force business
17 shall be equal to the sum of the risk adjusted employee risk rates.
18 The standard employee risk rates shall be in effect for no less than
19 six months.

20 (3) For a contract that a plan has discontinued offering, the risk
21 adjustment factor applied to the standard employee risk rates for
22 the first rating period of the new contract that the small employer
23 elects to purchase shall be no greater than the risk adjustment factor
24 applied in the prior rating period to the discontinued contract.
25 However, the risk adjusted employee risk rate may not be more
26 than 120 percent or less than 80 percent of the plan's applicable
27 standard employee risk rate until July 1, 1996. Effective July 1,
28 1996, this factor may not be more than 110 percent or less than 90
29 percent. The factor effective July 1, 1996, shall apply to in force
30 business at the earlier of either the time of renewal or July 1, 1997.
31 *Effective January 1, 2014, the risk adjustment factor shall be zero.*
32 The risk adjustment factor for a small employer may not be
33 modified more frequently than every 12 months.

34 (c) (1) For any small employer, a plan may, with the consent
35 of the small employer, establish composite employee and
36 dependent rates for either new business or renewal of in force
37 business. The composite rates shall be determined as the average
38 of the risk adjusted employee risk rates for the small employer, as
39 determined in accordance with the requirements of subdivisions
40 (a) and (b). The sum of the composite rates so determined shall be

1 equal to the sum of the risk adjusted employee risk rates for the
2 small employer.

3 (2) The composite rates shall be used for all employees and
4 dependents covered throughout a rating period of no less than six
5 months nor more than 12 months, except that a plan may reserve
6 the right to redetermine the composite rates if the enrollment under
7 the contract changes by more than a specified percentage during
8 the rating period. Any redetermination of the composite rates shall
9 be based on the same risk adjusted employee risk rates used to
10 determine the initial composite rates for the rating period. If a plan
11 reserves the right to redetermine the rates and the enrollment
12 changes more than the specified percentage, the plan shall
13 redetermine the composite rates if the redetermined rates would
14 result in a lower premium for the small employer. A plan reserving
15 the right to redetermine the composite rates based upon a change
16 in enrollment shall use the same specified percentage to measure
17 that change with respect to all small employers electing composite
18 rates.

19 SEC. 7. Section 1357.14 of the Health and Safety Code is
20 amended to read:

21 1357.14. In connection with the offering for sale of any plan
22 contract to a small employer, each plan shall make a reasonable
23 disclosure, as part of its solicitation and sales materials, of the
24 following:

25 (a) ~~The~~ *Until January 1, 2014, the* extent to which premium
26 rates for a specified small employer are established or adjusted in
27 part based upon the actual or expected variation in service costs
28 or actual or expected variation in health condition of the employees
29 and dependents of the small employer.

30 (b) The provisions concerning the plan's right to change
31 premium rates and the factors other than provision of services
32 experience that affect changes in premium rates.

33 (c) Provisions relating to the guaranteed issue and renewal of
34 contracts.

35 (d) ~~Provisions~~ *Until January 1, 2014, provisions* relating to the
36 effect of any preexisting condition provision.

37 (e) Provisions relating to the small employer's right to apply
38 for any contract written, issued, or administered by the plan at the
39 time of application for a new health care service plan contract, or
40 at the time of renewal of a health care service plan contract.

1 (f) The availability, upon request, of a listing of all the plan's
2 contracts and benefit plan designs offered to small employers,
3 including the rates for each contract.

4 (g) At the time it offers a contract to a small employer, each
5 plan shall provide the small employer with a statement of all of
6 its plan contracts offered to small employers, including the rates
7 for each plan contract, in the service area in which the employer's
8 employees and eligible dependents who are to be covered by the
9 plan contract work or reside. For purposes of this subdivision,
10 plans that are affiliated plans or that are eligible to file a
11 consolidated income tax return shall be treated as one health plan.

12 (h) Each plan shall do all of the following:

13 (1) Prepare a brochure that summarizes all of its plan contracts
14 offered to small employers and to make this summary available
15 to any small employer and to solicitors upon request. The summary
16 shall include for each contract information on benefits provided,
17 a generic description of the manner in which services are provided,
18 such as how access to providers is limited, benefit limitations,
19 required copayments and deductibles, standard employee risk rates,
20 *and, until January 1, 2014, an explanation of the manner in which*
21 *creditable coverage is calculated if a preexisting condition or*
22 *affiliation period is imposed,*~~and. The summary shall also include~~
23 *a phone number that can be called for more detailed benefit*
24 *information. Plans are required to keep the information contained*
25 *in the brochure accurate and up to date and, upon updating the*
26 *brochure, send copies to solicitors and solicitor firms with whom*
27 *the plan contracts to solicit enrollments or subscriptions.*

28 (2) For each contract, prepare a more detailed evidence of
29 coverage and make it available to small employers, solicitors, and
30 solicitor firms upon request. The evidence of coverage shall contain
31 all information that a prudent buyer would need to be aware of in
32 making contract selections.

33 (3) Provide to small employers and solicitors, upon request, for
34 any given small employer the sum of the standard employee risk
35 rates and the sum of the risk adjusted employee risk rates. When
36 requesting this information, small employers, solicitors, and
37 solicitor firms shall provide the plan with the information the plan
38 needs to determine the small employer's risk adjusted employee
39 risk rate.

1 (4) Provide copies of the current summary brochure to all
2 solicitors and solicitor firms contracting with the plan to solicit
3 enrollments or subscriptions from small employers.

4 For purposes of this subdivision, plans that are affiliated plans
5 or that are eligible to file a consolidated income tax return shall
6 be treated as one health plan.

7 (i) Every solicitor or solicitor firm contracting with one or more
8 plans to solicit enrollments or subscriptions from small employers
9 shall do all of the following:

10 (1) When providing information on contracts to a small
11 employer but making no specific recommendations on particular
12 plan contracts:

13 (A) Advise the small employer of the plan's obligation to sell
14 to any small employer any plan contract it offers to small
15 employers and provide them, upon request, with the actual rates
16 that would be charged to that employer for a given contract.

17 (B) Notify the small employer that the solicitor or solicitor firm
18 will procure rate and benefit information for the small employer
19 on any plan contract offered by a plan whose contract the solicitor
20 sells.

21 (C) Notify the small employer that upon request the solicitor or
22 solicitor firm will provide the small employer with the summary
23 brochure required under paragraph (1) of subdivision (h) for any
24 plan contract offered by a plan with whom the solicitor or solicitor
25 firm has contracted with to solicit enrollments or subscriptions.

26 *(D) Notify the small employer of the availability of coverage*
27 *through the California Health Benefit Exchange.*

28 (2) When recommending a particular benefit plan design or
29 designs, advise the small employer that, upon request, the agent
30 will provide the small employer with the brochure required by
31 paragraph (1) of subdivision (h) containing the benefit plan design
32 or designs being recommended by the agent or broker.

33 (3) Prior to filing an application for a small employer for a
34 particular contract:

35 (A) For each of the plan contracts offered by the plan whose
36 contract the solicitor or solicitor firm is offering, provide the small
37 employer with the benefit summary required in paragraph (1) of
38 subdivision (h) and the sum of the standard employee risk rates
39 for that particular employer.

(B) Notify the small employer that, upon request, the solicitor or solicitor firm will provide the small employer with an evidence of coverage brochure for each contract the plan offers.

(C) ~~Notify~~ *Until January 1, 2014, notify* the small employer that, from July 1, 1993, to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates, depending on how the plan assesses the risk of the small employer's group. *On or after January 1, 2014, notify the small employer that, effective January 1, 2014, the actual rates shall be the same for all small employers.*

(D) ~~Notify~~ *Until January 1, 2014, notify* the small employer that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the small employer's sum of the risk adjusted employee risk rate for any contract the plan offers. *On or after January 1, 2014, notify the small employer of the employee rate effective January 1, 2014.*

(E) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this section.

SEC. 8. Section 1357.15 of the Health and Safety Code is amended to read:

1357.15. (a) At least ~~20~~ 60 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. ~~The For~~ *rates in effect until January 1, 2014, the* certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least ~~20~~ 60 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material

1 modification with the director in accordance with the provisions
2 of Section 1352. The notice of material modification shall include
3 a statement certifying that the plan is in compliance with
4 subdivision (j) of Section 1357 and Section 1357.12. ~~The For rates~~
5 ~~in effect until January 1, 2014, the~~ certified statement shall set
6 forth the standard employee risk rate for each risk category and
7 the highest and lowest risk adjustment factors that will be used in
8 setting the rates at which the contract will be offered. Plans that
9 will be offering to a small employer plan contracts approved by
10 the director prior to the effective date of this article shall file a
11 notice of material modification in accordance with this subdivision.
12 Any action by the director, as permitted under Section 1352, to
13 disapprove, suspend, or postpone the plan's use of a plan contract
14 shall be in writing, specifying the reasons that the plan contract
15 does not comply with the requirements of this chapter.

16 (c) Prior to making any changes in the risk categories, risk
17 adjustment factors, or standard employee risk rates filed with the
18 director pursuant to subdivision (a) or (b), the plan shall file as an
19 amendment a statement setting forth the changes and certifying
20 that the plan is in compliance with subdivision (j) of Section 1357
21 and Section 1357.12. A plan may commence offering plan contracts
22 utilizing the changed risk categories set forth in the certified
23 statement on the 31st day from the date of the filing, or at an earlier
24 time determined by the director, unless the director disapproves
25 the amendment by written notice, stating the reasons therefor. If
26 only the standard employee risk rate is being changed, and not the
27 risk categories or risk adjustment factors, a plan may commence
28 offering plan contracts utilizing the changed standard employee
29 risk rate upon filing the certified statement unless the director
30 disapproves the amendment by written notice.

31 (d) Periodic changes to the standard employee risk rate that a
32 plan proposes to implement over the course of up to 12 consecutive
33 months may be filed in conjunction with the certified statement
34 filed under subdivision (a), (b), or (c).

35 (e) Each plan shall maintain at its principal place of business
36 all of the information required to be filed with the director pursuant
37 to this section.

38 (f) Each plan shall make available to the director, on request,
39 the risk adjustment factor used in determining the rate for any
40 particular small employer.

1 (g) Nothing in this section shall be construed to limit the
2 director's authority to enforce the rating practices set forth in this
3 article.

4 (h) *This section shall remain in effect only until January 1, 2014,*
5 *and as of that date is repealed, unless a later enacted statute, that*
6 *is enacted before January 1, 2014, deletes or extends that date.*

7 SEC. 9. Section 1357.15 is added to the Health and Safety
8 Code, to read:

9 1357.15. (a) At least 60 business days prior to renewing or
10 amending a plan contract subject to this article which will be in
11 force on the operative date of this article, a plan shall file a notice
12 of material modification with the director in accordance with the
13 provisions of Section 1352. The notice of material modification
14 shall include a statement certifying that the plan is in compliance
15 with subdivision (j) of Section 1357 and Section 1357.12. Any
16 action by the director, as permitted under Section 1352, to
17 disapprove, suspend, or postpone the plan's use of a plan contract
18 shall be in writing, specifying the reasons that the plan contract
19 does not comply with the requirements of this chapter.

20 (b) At least 60 business days prior to offering a plan contract
21 subject to this article, all plans shall file a notice of material
22 modification with the director in accordance with the provisions
23 of Section 1352. The notice of material modification shall include
24 a statement certifying that the plan is in compliance with
25 subdivision (j) of Section 1357 and Section 1357.12. Plans that
26 will be offering to a small employer plan contracts approved by
27 the director prior to the effective date of this article shall file a
28 notice of material modification in accordance with this subdivision.
29 Any action by the director, as permitted under Section 1352, to
30 disapprove, suspend, or postpone the plan's use of a plan contract
31 shall be in writing, specifying the reasons that the plan contract
32 does not comply with the requirements of this chapter.

33 (c) Prior to making any changes in the risk categories, risk
34 adjustment factors, or standard employee risk rates filed with the
35 director pursuant to subdivision (a) or (b), the plan shall file as an
36 amendment a statement setting forth the changes and certifying
37 that the plan is in compliance with subdivision (j) of Section 1357
38 and Section 1357.12. A plan may commence offering plan contracts
39 utilizing the changed risk categories set forth in the certified
40 statement on the 31st day from the date of the filing, or at an earlier

1 time determined by the director, unless the director disapproves
2 the amendment by written notice, stating the reasons therefor. If
3 only the standard employee risk rate is being changed, and not the
4 risk categories or risk adjustment factors, a plan may commence
5 offering plan contracts utilizing the changed standard employee
6 risk rate upon filing the certified statement unless the director
7 disapproves the amendment by written notice.

8 (d) Each plan shall maintain at its principal place of business
9 all of the information required to be filed with the director pursuant
10 to this section.

11 (e) Nothing in this section shall be construed to limit the
12 director's authority to enforce the rating practices set forth in this
13 article.

14 (f) This section shall become operative on January 1, 2014.

15 SEC. 10. Section 1357.18 is added to the Health and Safety
16 Code, to read:

17 1357.18. On or after January 1, 2012, if a health care service
18 plan offers a wellness program pursuant to a health care service
19 contract issued pursuant to this article, the wellness program shall
20 meet the following requirements:

21 (a) A rebate, discount, or other incentive offered under the
22 wellness program will not result in a variation in the premium of
23 greater than 1.2 to one and is not offered for copayments,
24 deductibles, or any other out-of-pocket costs for basic health care
25 services, as defined in subdivision (b) of Section 1345, or
26 prescription drug benefits, as described in this article.

27 (b) The wellness program meets the following standards:

28 (1) Is demonstrated by scientific evidence to improve health
29 outcomes as documented by peer-reviewed scientific evidence
30 involving multiple studies over time.

31 (2) Has approval of the department on an experimental basis as
32 part of the scientific research or a clinical trial that is conducted
33 by a recognized academic institution for a period not to exceed 24
34 months and that is expected to lead to the publication of
35 peer-reviewed scientific evidence.

36 (3) Is not based on an individual satisfying a standard that is
37 related to a health status factor, including the following:

38 (A) Health status.

39 (B) Medical condition, including both physical and mental
40 illnesses.

1 (C) Claims experience.

2 (D) Receipt of health care.

3 (E) Medical history.

4 (F) Genetic information.

5 (G) Evidence of insurability.

6 (H) Disability.

7 (I) Any other health status-related factor determined by guidance
8 issued pursuant to the federal Patient Protection and Affordable
9 Care Act (Public Law 111-148) or by the department through
10 regulations.

11 (4) Is not related to or statistically correlated with any of the
12 following:

13 (A) Medical history, risk factors, or health status indicators of
14 any kind.

15 (B) Genetic predisposition.

16 (C) Age.

17 SEC. 11. Section 1357.50 of the Health and Safety Code is
18 amended to read:

19 1357.50. For purposes of this article:

20 (a) "Health benefit plan" means any individual or group
21 insurance policy or health care service plan contract that provides
22 medical, hospital, and surgical benefits. The term does not include
23 accident only, credit, disability income, coverage of Medicare
24 services pursuant to contracts with the United States government,
25 Medicare supplement, long-term care insurance, dental, vision,
26 coverage issued as a supplement to liability insurance, insurance
27 arising out of a workers' compensation or similar law, automobile
28 medical payment insurance, or insurance under which benefits are
29 payable with or without regard to fault and that is statutorily
30 required to be contained in any liability insurance policy or
31 equivalent self-insurance.

32 (b) "Late enrollee" means an eligible employee or dependent
33 who has declined health coverage under a health benefit plan
34 offered through employment or sponsored by an employer at the
35 time of the initial enrollment period provided under the terms of
36 the health benefit plan, and who subsequently requests enrollment
37 in a health benefit plan of that employer, provided that the initial
38 enrollment period shall be a period of at least 30 days. However,
39 an eligible employee or dependent shall not be considered a late
40 enrollee if any of the following is applicable:

1 (1) The individual meets all of the following requirements:

2 (A) The individual was covered under another employer health
3 benefit plan, the Healthy Families Program, the Access for Infants
4 and Mothers (AIM) Program, ~~or~~ the Medi-Cal program, *or the*
5 *California Health Benefit Exchange*, at the time the individual was
6 eligible to enroll.

7 (B) The individual certified, at the time of the initial enrollment,
8 that coverage under another employer health benefit plan, the
9 Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal
10 program, *or the California Health Benefit Exchange* was the reason
11 for declining enrollment provided that, if the individual was
12 covered under another employer health benefit plan, the individual
13 was given the opportunity to make the certification required by
14 this subdivision and was notified that failure to do so could result
15 in later treatment as a late enrollee.

16 (C) The individual has lost or will lose coverage under another
17 employer health benefit plan as a result of termination of
18 employment of the individual or of a person through whom the
19 individual was covered as a dependent, change in employment
20 status of the individual or of a person through whom the individual
21 was covered as a dependent, termination of the other plan's
22 coverage, cessation of an employer's contribution toward an
23 employee or dependent's coverage, death of a person through
24 whom the individual was covered as a dependent, legal separation,
25 or divorce; or the individual has lost or will lose coverage under
26 the Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal
27 program, *or the California Health Benefit Exchange*.

28 (D) The individual requests enrollment within 30 days after
29 termination of coverage, or cessation of employer contribution
30 toward coverage provided under another employer health benefit
31 plan, or requests enrollment within 60 days after termination of
32 Medi-Cal program coverage, AIM Program coverage, ~~or~~ Healthy
33 Families Program coverage, *or coverage through the California*
34 *Health Benefit Exchange*.

35 (2) The individual is employed by an employer that offers
36 multiple health benefit plans and the individual elects a different
37 plan during an open enrollment period.

38 (3) A court has ordered that coverage be provided for a spouse
39 or minor child under a covered employee's health benefit plan.
40 The health benefit plan shall enroll a dependent child within 30

1 days after receipt of a court order or request from the district
2 attorney, either parent or the person having custody of the child
3 as defined in Section 3751.5 of the Family Code, the employer,
4 or the group administrator. In the case of children who are eligible
5 for Medicaid, the State Department of Health Care Services may
6 also make the request.

7 (4) The plan cannot produce a written statement from the
8 employer stating that, prior to declining coverage, the individual
9 or the person through whom the individual was eligible to be
10 covered as a dependent was provided with, and signed
11 acknowledgment of, explicit written notice in boldface type
12 specifying that failure to elect coverage during the initial
13 enrollment period permits the plan to impose, at the time of the
14 individual's later decision to elect coverage, an exclusion from
15 coverage for a period of 12 months as well as a six-month
16 preexisting condition exclusion, unless the individual meets the
17 criteria specified in paragraph (1), (2), or (3).

18 (5) The individual is an employee or dependent who meets the
19 criteria described in paragraph (1) and was under a COBRA
20 continuation provision, and the coverage under that provision has
21 been exhausted. For purposes of this section, the definition of
22 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
23 apply.

24 (6) The individual is a dependent of an enrolled eligible
25 employee who has lost or will lose his or her coverage under the
26 Healthy Families Program, the AIM Program, ~~or the Medi-Cal~~
27 program, *or the California Health Benefit Exchange*, and requests
28 enrollment within 60 days of termination of that coverage.

29 (7) The individual is an eligible employee who previously
30 declined coverage under an employer health benefit plan and who
31 has subsequently acquired a dependent who would be eligible for
32 coverage as a dependent of the employee through marriage, birth,
33 adoption, or placement for adoption, and who enrolls for coverage
34 under that employer health benefit plan on his or her behalf, and
35 on behalf of his or her dependent within 30 days following the
36 date of marriage, birth, adoption, or placement for adoption, in
37 which case the effective date of coverage shall be the first day of
38 the month following the date the completed request for enrollment
39 is received in the case of marriage, or the date of birth, or the date
40 of adoption or placement for adoption, whichever applies. Notice

of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(c) ~~“Preexisting”~~ *Until January 1, 2014, “preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee’s effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. On or after January 1, 2014, “preexisting condition” means, with respect to coverage, a prohibited limitation or exclusion based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.*

(d) “Creditable coverage” means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurance company, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or

1 conversion coverage but does not include accident only, credit,
2 coverage for onsite medical clinics, disability income, Medicare
3 supplement, long-term care insurance, dental, vision, coverage
4 issued as a supplement to liability insurance, insurance arising out
5 of a workers' compensation or similar law, automobile medical
6 payment insurance, or insurance under which benefits are payable
7 with or without regard to fault and that is statutorily required to
8 be contained in any liability insurance policy or equivalent
9 self-insurance.

10 (2) The Medicare Program pursuant to Title XVIII of the federal
11 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

12 (3) The Medicaid Program pursuant to Title XIX of the federal
13 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

14 (4) Any other publicly sponsored program, provided in this state
15 or elsewhere, of medical, hospital, and surgical care.

16 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
17 (Civilian Health and Medical Program of the Uniformed Services
18 (CHAMPUS)).

19 (6) A medical care program of the Indian Health Service or of
20 a tribal organization.

21 (7) A state health benefits risk pool.

22 (8) A health plan offered under 5 U.S.C. Chapter 89
23 (commencing with Section 8901) (Federal Employees Health
24 Benefits Program (FEHBP)).

25 (9) A public health plan as defined in federal regulations
26 authorized by Section 2701(c)(1)(I) of the Public Health Service
27 Act, as amended by Public Law 104-191, the Health Insurance
28 Portability and Accountability Act of 1996.

29 (10) A health benefit plan under Section 5(e) of the Peace Corps
30 Act (22 U.S.C. Sec. 2504(e)).

31 (11) Any other creditable coverage as defined by subdivision
32 (c) of Section 2701 of Title XXVII of the federal Public Health
33 Service Act (42 U.S.C. Sec. 300gg(c)).

34 (e) "Waivered condition" means a contract provision that
35 excludes coverage for charges or expenses incurred during a
36 specified period of time for one or more specific, identified,
37 medical conditions.

38 (f) "Affiliation period" means a period that, under the terms of
39 the health benefit plan, must expire before health care services
40 under the plan become effective.

1 (g) *This section shall remain in effect only until January 1, 2014,*
2 *and as of that date is repealed, unless a later enacted statute, that*
3 *is enacted before January 1, 2014, deletes or extends that date.*

4 SEC. 12. Section 1357.50 is added to the Health and Safety
5 Code, to read:

6 1357.50. For purposes of this article:

7 (a) “Health benefit plan” means any individual or group
8 insurance policy or health care service plan contract that provides
9 medical, hospital, and surgical benefits. The term does not include
10 accident only, credit, disability income, coverage of Medicare
11 services pursuant to contracts with the United States government,
12 Medicare supplement, long-term care insurance, dental, vision,
13 coverage issued as a supplement to liability insurance, insurance
14 arising out of a workers’ compensation or similar law, automobile
15 medical payment insurance, or insurance under which benefits are
16 payable with or without regard to fault and that is statutorily
17 required to be contained in any liability insurance policy or
18 equivalent self-insurance.

19 (b) “Late enrollee” means an eligible employee or dependent
20 who has declined health coverage under a health benefit plan
21 offered through employment or sponsored by an employer at the
22 time of the initial enrollment period provided under the terms of
23 the health benefit plan, and who subsequently requests enrollment
24 in a health benefit plan of that employer, provided that the initial
25 enrollment period shall be a period of at least 30 days. However,
26 an eligible employee or dependent shall not be considered a late
27 enrollee if any of the following is applicable:

28 (1) The individual meets all of the following requirements:

29 (A) The individual was covered under another employer health
30 benefit plan, the Healthy Families Program, the Access for Infants
31 and Mothers (AIM) Program, the Medi-Cal program, or the
32 California Health Benefit Exchange, at the time the individual was
33 eligible to enroll.

34 (B) The individual certified, at the time of the initial enrollment,
35 that coverage under another employer health benefit plan, the
36 Healthy Families Program, the AIM Program, the Medi-Cal
37 program, or the California Health Benefit Exchange was the reason
38 for declining enrollment provided that, if the individual was
39 covered under another employer health benefit plan, the individual
40 was given the opportunity to make the certification required by

1 this subdivision and was notified that failure to do so could result
2 in later treatment as a late enrollee.

3 (C) The individual has lost or will lose coverage under another
4 employer health benefit plan as a result of termination of
5 employment of the individual or of a person through whom the
6 individual was covered as a dependent, change in employment
7 status of the individual or of a person through whom the individual
8 was covered as a dependent, termination of the other plan's
9 coverage, cessation of an employer's contribution toward an
10 employee or dependent's coverage, death of a person through
11 whom the individual was covered as a dependent, legal separation,
12 or divorce; or the individual has lost or will lose coverage under
13 the Healthy Families Program, the AIM Program, the Medi-Cal
14 program, or the California Health Benefit Exchange.

15 (D) The individual requests enrollment within 30 days after
16 termination of coverage, or cessation of employer contribution
17 toward coverage provided under another employer health benefit
18 plan, or requests enrollment within 60 days after termination of
19 Medi-Cal program coverage, AIM Program coverage, Healthy
20 Families Program coverage, or coverage through the California
21 Health Benefit Exchange.

22 (2) The individual is employed by an employer that offers
23 multiple health benefit plans and the individual elects a different
24 plan during an open enrollment period.

25 (3) A court has ordered that coverage be provided for a spouse
26 or minor child under a covered employee's health benefit plan.
27 The health benefit plan shall enroll a dependent child within 30
28 days after receipt of a court order or request from the district
29 attorney, either parent or the person having custody of the child
30 as defined in Section 3751.5 of the Family Code, the employer,
31 or the group administrator. In the case of children who are eligible
32 for Medicaid, the State Department of Health Care Services may
33 also make the request.

34 (4) The plan cannot produce a written statement from the
35 employer stating that, prior to declining coverage, the individual
36 or the person through whom the individual was eligible to be
37 covered as a dependent was provided with, and signed
38 acknowledgment of, explicit written notice in boldface type
39 specifying that failure to elect coverage during the initial
40 enrollment period permits the plan to impose, at the time of the

1 individual's later decision to elect coverage, an exclusion from
2 coverage for a period of 12 months as well as a six-month
3 preexisting condition exclusion, unless the individual meets the
4 criteria specified in paragraph (1), (2), or (3).

5 (5) The individual is an employee or dependent who meets the
6 criteria described in paragraph (1) and was under a COBRA
7 continuation provision, and the coverage under that provision has
8 been exhausted. For purposes of this section, the definition of
9 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
10 apply.

11 (6) The individual is a dependent of an enrolled eligible
12 employee who has lost or will lose his or her coverage under the
13 Healthy Families Program, the AIM Program, the Medi-Cal
14 program, or the California Health Benefit Exchange, and requests
15 enrollment within 60 days of termination of that coverage.

16 (7) The individual is an eligible employee who previously
17 declined coverage under an employer health benefit plan and who
18 has subsequently acquired a dependent who would be eligible for
19 coverage as a dependent of the employee through marriage, birth,
20 adoption, or placement for adoption, and who enrolls for coverage
21 under that employer health benefit plan on his or her behalf, and
22 on behalf of his or her dependent within 30 days following the
23 date of marriage, birth, adoption, or placement for adoption, in
24 which case the effective date of coverage shall be the first day of
25 the month following the date the completed request for enrollment
26 is received in the case of marriage, or the date of birth, or the date
27 of adoption or placement for adoption, whichever applies. Notice
28 of the special enrollment rights contained in this paragraph shall
29 be provided by the employer to an employee at or before the time
30 the employee is offered an opportunity to enroll in plan coverage.

31 (8) The individual is an eligible employee who has declined
32 coverage for himself or herself or his or her dependents during a
33 previous enrollment period because his or her dependents were
34 covered by another employer health benefit plan at the time of the
35 previous enrollment period. That individual may enroll himself or
36 herself or his or her dependents for plan coverage during a special
37 open enrollment opportunity if his or her dependents have lost or
38 will lose coverage under that other employer health benefit plan.
39 The special open enrollment opportunity shall be requested by the
40 employee not more than 30 days after the date that the other health

1 coverage is exhausted or terminated. Upon enrollment, coverage
2 shall be effective not later than the first day of the first calendar
3 month beginning after the date the request for enrollment is
4 received. Notice of the special enrollment rights contained in this
5 paragraph shall be provided by the employer to an employee at or
6 before the time the employee is offered an opportunity to enroll
7 in plan coverage.

8 (c) Until January 1, 2014, “preexisting condition provision”
9 means a contract provision that excludes coverage for charges or
10 expenses incurred during a specified period following the enrollee’s
11 effective date of coverage, as to a condition for which medical
12 advice, diagnosis, care, or treatment was recommended or received
13 during a specified period immediately preceding the effective date
14 of coverage. On or after January 1, 2014, “preexisting condition”
15 means, with respect to coverage, a prohibited limitation or
16 exclusion based on the fact that the condition was present before
17 the date of enrollment of the coverage, whether or not any medical
18 advice, diagnosis, care, or treatment was recommended or received
19 before that date.

20 (d) “Creditable coverage” means:

21 (1) Any individual or group policy, contract, or program that is
22 written or administered by a disability insurance company,
23 nonprofit hospital service plan, health care service plan, fraternal
24 benefits society, self-insured employer plan, or any other entity,
25 in this state or elsewhere, and that arranges or provides medical,
26 hospital, and surgical coverage not designed to supplement other
27 private or governmental plans. The term includes continuation or
28 conversion coverage but does not include accident only, credit,
29 coverage for onsite medical clinics, disability income, Medicare
30 supplement, long-term care insurance, dental, vision, coverage
31 issued as a supplement to liability insurance, insurance arising out
32 of a workers’ compensation or similar law, automobile medical
33 payment insurance, or insurance under which benefits are payable
34 with or without regard to fault and that is statutorily required to
35 be contained in any liability insurance policy or equivalent
36 self-insurance.

37 (2) The Medicare Program pursuant to Title XVIII of the federal
38 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

39 (3) The Medicaid Program pursuant to Title XIX of the federal
40 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

1 (4) Any other publicly sponsored program, provided in this state
2 or elsewhere, of medical, hospital, and surgical care.

3 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
4 (Civilian Health and Medical Program of the Uniformed Services
5 (CHAMPUS)).

6 (6) A medical care program of the Indian Health Service or of
7 a tribal organization.

8 (7) A state health benefits risk pool.

9 (8) A health plan offered under 5 U.S.C. Chapter 89
10 (commencing with Section 8901) (Federal Employees Health
11 Benefits Program (FEHBP)).

12 (9) A public health plan as defined in federal regulations
13 authorized by Section 2701(c)(1)(I) of the Public Health Service
14 Act, as amended by Public Law 104-191, the Health Insurance
15 Portability and Accountability Act of 1996.

16 (10) A health benefit plan under Section 5(e) of the Peace Corps
17 Act (22 U.S.C. Sec. 2504(e)).

18 (11) Any other creditable coverage as defined by subdivision
19 (c) of Section 2701 of Title XXVII of the federal Public Health
20 Service Act (42 U.S.C. Sec. 300gg(c)).

21 (e) This section shall become operative on January 1, 2014.

22 SEC. 13. Section 1357.51 of the Health and Safety Code is
23 amended to read:

24 1357.51. (a) ~~No~~ *Until January 1, 2014, no* plan contract that
25 covers three or more enrollees shall exclude coverage for any
26 individual on the basis of a preexisting condition provision for a
27 period greater than six months following the individual's effective
28 date of coverage. Preexisting condition provisions contained in
29 plan contracts may relate only to conditions for which medical
30 advice, diagnosis, care, or treatment, including use of prescription
31 drugs, was recommended or received from a licensed health
32 practitioner during the six months immediately preceding the
33 effective date of coverage. *On and after January 1, 2014, no plan*
34 *contract that covers one or more enrollees shall exclude coverage*
35 *for any individual on the basis of a preexisting condition.*

36 (b) ~~No~~ *Until January 1, 2014, no* plan contract that covers one
37 or two individuals shall exclude coverage on the basis of a
38 preexisting condition provision for a period greater than 12 months
39 following the individual's effective date of coverage, nor shall the
40 plan limit or exclude coverage for a specific enrollee by type of

1 illness, treatment, medical condition, or accident, except for
2 satisfaction of a preexisting condition clause pursuant to this article.
3 Preexisting condition provisions contained in plan contracts may
4 relate only to conditions for which medical advice, diagnosis, care,
5 or treatment, including use of prescription drugs, was recommended
6 or received from a licensed health practitioner during the 12 months
7 immediately preceding the effective date of coverage.

8 (c) (1) Notwithstanding subdivision (a), a plan contract for
9 group coverage shall not impose any preexisting condition
10 provision upon any child under 19 years of age.

11 (2) Notwithstanding subdivision (b), a plan contract for
12 individual coverage that is not a grandfathered health *plan* within
13 the meaning of Section 1251 of the federal Patient Protection and
14 Affordable Care Act (Public Law 111-148) shall not impose any
15 preexisting condition provision upon any child under 19 years of
16 age.

17 (d) ~~A—Until January 1, 2014, a plan that does not utilize a~~
18 preexisting condition provision may impose a waiting or affiliation
19 period not to exceed 60 days, before the coverage issued subject
20 to this article shall become effective. During the waiting or
21 affiliation period, the plan is not required to provide health care
22 services and no premium shall be charged to the subscriber or
23 enrollee.

24 (e) ~~A—Until January 1, 2014, a plan that does not utilize a~~
25 preexisting condition provision in plan contracts that cover one or
26 two individuals may impose a contract provision excluding
27 coverage for waived conditions. No plan may exclude coverage
28 on the basis of a waived condition for a period greater than 12
29 months following the individual's effective date of coverage. A
30 waived condition provision contained in plan contracts may
31 relate only to conditions for which medical advice, diagnosis, care,
32 or treatment, including use of prescription drugs, was recommended
33 or received from a licensed health practitioner during the 12 months
34 immediately preceding the effective date of coverage.

35 (f) ~~In—Until January 1, 2014, in~~ determining whether a
36 preexisting condition provision, a waived condition provision,
37 or a waiting or affiliation period applies to any enrollee, a plan
38 shall credit the time the enrollee was covered under creditable
39 coverage, provided that the enrollee becomes eligible for coverage
40 under the succeeding plan contract within 62 days of termination

1 of prior coverage, exclusive of any waiting or affiliation period,
2 and applies for coverage under the succeeding plan within the
3 applicable enrollment period. A plan shall also credit any time that
4 an eligible employee must wait before enrolling in the plan,
5 including any postenrollment or employer-imposed waiting or
6 affiliation period.

7 However, if a person's employment has ended, the availability
8 of health coverage offered through employment or sponsored by
9 an employer has terminated, or an employer's contribution toward
10 health coverage has terminated, a plan shall credit the time the
11 person was covered under creditable coverage if the person
12 becomes eligible for health coverage offered through employment
13 or sponsored by an employer within 180 days, exclusive of any
14 waiting or affiliation period, and applies for coverage under the
15 succeeding plan contract within the applicable enrollment period.

16 (g) ~~No~~ (1) *Until January 1, 2014, no plan shall exclude late*
17 *enrollees from coverage for more than 12 months from the date*
18 *of the late enrollee's application for coverage. No plan shall require*
19 *any premium or other periodic charge to be paid by or on behalf*
20 *of a late enrollee during the period of exclusion from coverage*
21 *permitted by this subdivision.*

22 (2) *On or after January 1, 2014, a plan may impose a 90-day*
23 *waiting period from the date of the late enrollee's application for*
24 *coverage. No plan shall require any premium or other periodic*
25 *charge to be paid by or on behalf of a late enrollee during the*
26 *period of exclusion from coverage permitted by this subdivision.*

27 (h) A health care service plan issuing group coverage may not
28 impose a preexisting condition exclusion upon a condition relating
29 to benefits for pregnancy or maternity care.

30 (i) An individual's period of creditable coverage shall be
31 certified pursuant to subsection (e) of Section 2701 of Title XXVII
32 of the federal Public Health Services Service Act (42 U.S.C. Sec.
33 300gg(e)).

34 (j) *This section shall remain in effect only until January 1, 2014,*
35 *and as of that date is repealed, unless a later enacted statute, that*
36 *is enacted before January 1, 2014, deletes or extends that date.*

37 SEC. 14. Section 1357.51 is added to the Health and Safety
38 Code, to read:

1 1357.51. (a) No plan contract that covers one or more enrollees
2 shall exclude coverage for any individual on the basis of a
3 preexisting condition.

4 (b) (1) A plan contract for group coverage shall not impose any
5 preexisting condition provision upon any child under 19 years of
6 age.

7 (2) A plan contract for individual coverage that is not a
8 grandfathered health plan within the meaning of Section 1251 of
9 the federal Patient Protection and Affordable Care Act (Public
10 Law 111-148) shall not impose any preexisting condition provision
11 upon any child under 19 years of age.

12 (c) A plan may impose a 90-day waiting period from the date
13 of the late enrollee's application for coverage. No plan shall require
14 any premium or other periodic charge to be paid by or on behalf
15 of a late enrollee during the period of exclusion from coverage
16 permitted by this subdivision.

17 (d) A health care service plan issuing group coverage may not
18 impose a preexisting condition exclusion upon a condition relating
19 to benefits for pregnancy or maternity care.

20 (e) An individual's period of creditable coverage shall be
21 certified pursuant to subsection (e) of Section 2701 of Title XXVII
22 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(e)).

23 (f) This section shall become operative on January 1, 2014.

24 SEC. 15. Section 1357.52 of the Health and Safety Code is
25 amended to read:

26 1357.52. ~~Except~~(a) *Until January 1, 2014, except* in the case
27 of a late enrollee, or for satisfaction of a preexisting condition
28 clause in the case of initial coverage of an eligible employee, a
29 plan may not exclude any eligible employee or dependent who
30 would otherwise be entitled to health care services on the basis of
31 any of the following: the health status, the medical condition,
32 including both physical and mental illnesses, the claims experience,
33 the medical history, the genetic information, or the disability or
34 evidence of insurability including conditions arising out of acts of
35 domestic violence of that employee or dependent. No plan contract
36 may limit or exclude coverage for a specific eligible employee or
37 dependent by type of illness, treatment, medical condition, or
38 accident, except for preexisting conditions as permitted by Section
39 1357.06.

1 **(b)** *On or after January 1, 2014, a plan may not exclude any*
2 *eligible employee or dependent who would otherwise be entitled*
3 *to health care services on the basis of any of the following: the*
4 *health status, the medical condition, including both physical and*
5 *mental illnesses, the claims experience, the medical history, the*
6 *genetic information, or the disability or evidence of insurability,*
7 *including conditions arising out of acts of domestic violence, of*
8 *that employee or dependent. No plan contract may limit or exclude*
9 *coverage for a specific eligible employee or dependent by type of*
10 *illness, treatment, medical condition, or accident.*

11 **(c)** *This section shall remain in effect only until January 1, 2014,*
12 *and as of that date is repealed, unless a later enacted statute, that*
13 *is enacted before January 1, 2014, deletes or extends that date.*

14 SEC. 16. Section 1357.52 is added to the Health and Safety
15 Code, to read:

16 1357.52. A plan may not exclude any eligible employee or
17 dependent who would otherwise be entitled to health care services
18 on the basis of any of the following: the health status, the medical
19 condition, including both physical and mental illnesses, the claims
20 experience, the medical history, the genetic information, or the
21 disability or evidence of insurability including conditions arising
22 out of acts of domestic violence of that employee or dependent.
23 No plan contract may limit or exclude coverage for a specific
24 eligible employee or dependent by type of illness, treatment,
25 medical condition, or accident.

26 This section shall become operative on January 1, 2014.

27 SEC. 17. Section 10198.6 of the Insurance Code is amended
28 to read:

29 10198.6. For purposes of this article:

30 **(a)** “Health benefit plan” means any group or individual policy
31 or contract that provides medical, hospital, or surgical benefits.
32 The term does not include accident only, credit, disability income,
33 coverage of Medicare services pursuant to contracts with the United
34 States government, Medicare supplement, long-term care insurance,
35 dental, vision, coverage issued as a supplement to liability
36 insurance, insurance arising out of a workers’ compensation or
37 similar law, automobile medical payment insurance, or insurance
38 under which benefits are payable with or without regard to fault
39 and that is statutorily required to be contained in any liability
40 insurance policy or equivalent self-insurance.

(b) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, ~~or~~ the Medi-Cal program, *or the California Health Benefit Exchange*, at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment, that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal program, *or the California Health Benefit Exchange* was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of a person through whom the individual was covered as a dependent, legal separation, or divorce; or the individual has lost or will lose coverage under the Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal program, *or the California Health Benefit Exchange*.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of

1 Medi-Cal program coverage, AIM Program coverage, ~~or~~ Healthy
2 Families Program coverage, *or coverage through the California*
3 *Health Benefit Exchange*.

4 (2) The individual is employed by an employer that offers
5 multiple health benefit plans and the individual elects a different
6 plan during an open enrollment period.

7 (3) A court has ordered that coverage be provided for a spouse
8 or minor child under a covered employee's health benefit plan.

9 (4) The carrier cannot produce a written statement from the
10 employer stating that, prior to declining coverage, the individual
11 or the person through whom the individual was eligible to be
12 covered as a dependent was provided with, and signed
13 acknowledgment of, explicit written notice in boldface type
14 specifying that failure to elect coverage during the initial
15 enrollment period permits the carrier to impose, at the time of the
16 individual's later decision to elect coverage, an exclusion from
17 coverage for a period of 12 months as well as a six-month
18 preexisting condition exclusion, unless the individual meets the
19 criteria specified in paragraph (1), (2), or (3).

20 (5) The individual is an employee or dependent who meets the
21 criteria described in paragraph (1) and was under a COBRA
22 continuation provision and the coverage under that provision has
23 been exhausted. For purposes of this section, the definition of
24 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
25 apply.

26 (6) The individual is a dependent of an enrolled eligible
27 employee who has lost or will lose his or her coverage under the
28 Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal
29 program, *or the California Health Benefit Exchange*, and requests
30 enrollment within 60 days of termination of that coverage.

31 (c) ~~"Preexisting"~~ *Until January 1, 2014, "preexisting condition*
32 *provision" means a policy provision that excludes coverage for*
33 *charges or expenses incurred during a specified period following*
34 *the insured's effective date of coverage, as to a condition for which*
35 *medical advice, diagnosis, care, or treatment was recommended*
36 *or received during a specified period immediately preceding the*
37 *effective date of coverage. On or after January 1, 2014,*
38 *"preexisting condition" means, with respect to coverage, a*
39 *prohibited limitation or exclusion based on the fact that the*
40 *condition was present before the date of enrollment of the*

1 *coverage, whether or not any medical advice, diagnosis, care, or*
2 *treatment was recommended or received before that date.*

3 (d) “Creditable coverage” means:

4 (1) Any individual or group policy, contract or program, that is
5 written or administered by a disability insurance company, health
6 care service plan, fraternal benefits society, self-insured employer
7 plan, or any other entity, in this state or elsewhere, and that
8 arranges or provides medical, hospital, and surgical coverage not
9 designed to supplement other private or governmental plans. The
10 term includes continuation or conversion coverage but does not
11 include accident only, credit, coverage for onsite medical clinics,
12 disability income, Medicare supplement, long-term care insurance,
13 dental, vision, coverage issued as a supplement to liability
14 insurance, insurance arising out of a workers’ compensation or
15 similar law, automobile medical payment insurance, or insurance
16 under which benefits are payable with or without regard to fault
17 and that is statutorily required to be contained in any liability
18 insurance policy or equivalent self-insurance.

19 (2) The federal Medicare Program pursuant to Title XVIII of
20 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

21 (3) The Medicaid Program pursuant to Title XIX of the federal
22 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

23 (4) Any other publicly sponsored program, provided in this state
24 or elsewhere, of medical, hospital, and surgical care.

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

28 (6) A medical care program of the Indian Health Service or of
29 a tribal organization.

30 (7) A state health benefits risk pool.

31 (8) A health plan offered under 5 U.S.C. Chapter 89
32 (commencing with Section 8901) (Federal Employees Health
33 Benefits Program (FEHBP)).

34 (9) A public health plan as defined in federal regulations
35 authorized by Section 2701(c)(1)(I) of the federal Public Health
36 Service Act, as amended by Public Law 104-191, the federal Health
37 Insurance Portability and Accountability Act of 1996.

38 (10) A health benefit plan under Section 5(e) of the federal
39 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

1 (11) Any other creditable coverage as defined by subsection (c)
2 of Section 2701 of Title XXVII of the federal Public Health Service
3 Act (42 U.S.C. Sec. 300gg(c)).

4 (e) “Affiliation period” means a period that, under the terms of
5 the health benefit plan, must expire before health care services
6 under the plan become effective.

7 (f) “Waivered condition” means a contract provision that
8 excludes coverage for charges or expenses incurred during a
9 specified period of time for one or more specific, identified,
10 medical conditions.

11 (g) *This section shall remain in effect only until January 1, 2014,*
12 *and as of that date is repealed, unless a later enacted statute, that*
13 *is enacted before January 1, 2014, deletes or extends that date.*

14 SEC. 18. Section 10198.6 is added to the Insurance Code, to
15 read:

16 10198.6. For purposes of this article:

17 (a) “Health benefit plan” means any group or individual policy
18 or contract that provides medical, hospital, or surgical benefits.
19 The term does not include accident only, credit, disability income,
20 coverage of Medicare services pursuant to contracts with the United
21 States government, Medicare supplement, long-term care insurance,
22 dental, vision, coverage issued as a supplement to liability
23 insurance, insurance arising out of a workers’ compensation or
24 similar law, automobile medical payment insurance, or insurance
25 under which benefits are payable with or without regard to fault
26 and that is statutorily required to be contained in any liability
27 insurance policy or equivalent self-insurance.

28 (b) “Late enrollee” means an eligible employee or dependent
29 who has declined health coverage under a health benefit plan
30 offered through employment or sponsored by an employer at the
31 time of the initial enrollment period provided under the terms of
32 the health benefit plan, and who subsequently requests enrollment
33 in a health benefit plan of that employer, provided that the initial
34 enrollment period shall be a period of at least 30 days. However,
35 an eligible employee or dependent shall not be considered a late
36 enrollee if any of the following is applicable:

37 (1) The individual meets all of the following requirements:

38 (A) The individual was covered under another employer health
39 benefit plan, the Healthy Families Program, the Access for Infants
40 and Mothers (AIM) Program, the Medi-Cal program, or the

1 California Health Benefit Exchange, at the time the individual was
2 eligible to enroll.

3 (B) The individual certified, at the time of the initial enrollment,
4 that coverage under another employer health benefit plan, the
5 Healthy Families Program, the AIM Program, the Medi-Cal
6 program, or the California Health Benefit Exchange was the reason
7 for declining enrollment provided that, if the individual was
8 covered under another employer health benefit plan, the individual
9 was given the opportunity to make the certification required by
10 this subdivision and was notified that failure to do so could result
11 in later treatment as a late enrollee.

12 (C) The individual has lost or will lose coverage under another
13 employer health benefit plan as a result of termination of
14 employment of the individual or of a person through whom the
15 individual was covered as a dependent, change in employment
16 status of the individual or of a person through whom the individual
17 was covered as a dependent, termination of the other plan's
18 coverage, cessation of an employer's contribution toward an
19 employee or dependent's coverage, death of a person through
20 whom the individual was covered as a dependent, legal separation,
21 or divorce; or the individual has lost or will lose coverage under
22 the Healthy Families Program, the AIM Program, the Medi-Cal
23 program, or the California Health Benefit Exchange.

24 (D) The individual requests enrollment within 30 days after
25 termination of coverage, or cessation of employer contribution
26 toward coverage provided under another employer health benefit
27 plan, or requests enrollment within 60 days after termination of
28 Medi-Cal program coverage, AIM Program coverage, Healthy
29 Families Program coverage, or coverage through the California
30 Health Benefit Exchange.

31 (2) The individual is employed by an employer that offers
32 multiple health benefit plans and the individual elects a different
33 plan during an open enrollment period.

34 (3) A court has ordered that coverage be provided for a spouse
35 or minor child under a covered employee's health benefit plan.

36 (4) The carrier cannot produce a written statement from the
37 employer stating that, prior to declining coverage, the individual
38 or the person through whom the individual was eligible to be
39 covered as a dependent was provided with, and signed
40 acknowledgment of, explicit written notice in boldface type

1 specifying that failure to elect coverage during the initial
2 enrollment period permits the carrier to impose, at the time of the
3 individual's later decision to elect coverage, an exclusion from
4 coverage for a period of 12 months as well as a six-month
5 preexisting condition exclusion, unless the individual meets the
6 criteria specified in paragraph (1), (2), or (3).

7 (5) The individual is an employee or dependent who meets the
8 criteria described in paragraph (1) and was under a COBRA
9 continuation provision and the coverage under that provision has
10 been exhausted. For purposes of this section, the definition of
11 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
12 apply.

13 (6) The individual is a dependent of an enrolled eligible
14 employee who has lost or will lose his or her coverage under the
15 Healthy Families Program, the AIM Program, the Medi-Cal
16 program, or the California Health Benefit Exchange, and requests
17 enrollment within 60 days of termination of that coverage.

18 (c) Until January 1, 2014, "preexisting condition provision"
19 means a policy provision that excludes coverage for charges or
20 expenses incurred during a specified period following the insured's
21 effective date of coverage, as to a condition for which medical
22 advice, diagnosis, care, or treatment was recommended or received
23 during a specified period immediately preceding the effective date
24 of coverage. On or after January 1, 2014, "preexisting condition"
25 means, with respect to coverage, a prohibited limitation or
26 exclusion based on the fact that the condition was present before
27 the date of enrollment of the coverage, whether or not any medical
28 advice, diagnosis, care, or treatment was recommended or received
29 before that date.

30 (d) "Creditable coverage" means:

31 (1) Any individual or group policy, contract or program, that is
32 written or administered by a disability insurance company, health
33 care service plan, fraternal benefits society, self-insured employer
34 plan, or any other entity, in this state or elsewhere, and that
35 arranges or provides medical, hospital, and surgical coverage not
36 designed to supplement other private or governmental plans. The
37 term includes continuation or conversion coverage but does not
38 include accident only, credit, coverage for onsite medical clinics,
39 disability income, Medicare supplement, long-term care insurance,
40 dental, vision, coverage issued as a supplement to liability

1 insurance, insurance arising out of a workers' compensation or
2 similar law, automobile medical payment insurance, or insurance
3 under which benefits are payable with or without regard to fault
4 and that is statutorily required to be contained in any liability
5 insurance policy or equivalent self-insurance.

6 (2) The federal Medicare Program pursuant to Title XVIII of
7 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

8 (3) The Medicaid Program pursuant to Title XIX of the federal
9 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

10 (4) Any other publicly sponsored program, provided in this state
11 or elsewhere, of medical, hospital, and surgical care.

12 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
13 (Civilian Health and Medical Program of the Uniformed Services
14 (CHAMPUS)).

15 (6) A medical care program of the Indian Health Service or of
16 a tribal organization.

17 (7) A state health benefits risk pool.

18 (8) A health plan offered under 5 U.S.C. Chapter 89
19 (commencing with Section 8901) (Federal Employees Health
20 Benefits Program (FEHBP)).

21 (9) A public health plan as defined in federal regulations
22 authorized by Section 2701(c)(1)(I) of the federal Public Health
23 Service Act, as amended by Public Law 104-191, the federal Health
24 Insurance Portability and Accountability Act of 1996.

25 (10) A health benefit plan under Section 5(e) of the federal
26 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

27 (11) Any other creditable coverage as defined by subsection (c)
28 of Section 2701 of Title XXVII of the federal Public Health Service
29 Act (42 U.S.C. Sec. 300gg(c)).

30 (e) This section shall become operative on January 1, 2014.

31 SEC. 19. Section 10198.7 of the Insurance Code is amended
32 to read:

33 10198.7. (a) ~~No~~(1) *Until January 1, 2014, no* health benefit
34 plan that covers three or more persons and that is issued, renewed,
35 or written by any insurer, nonprofit hospital service plan,
36 self-insured employee welfare benefit plan, fraternal benefits
37 society, or any other entity shall exclude coverage for any
38 individual on the basis of a preexisting condition provision for a
39 period greater than six months following the individual's effective
40 date of coverage, nor shall limit or exclude coverage for a specific

1 insured person by type of illness, treatment, medical condition, or
2 accident except for satisfaction of a preexisting clause pursuant to
3 this article. Preexisting condition provisions contained in health
4 benefit plans may relate only to conditions for which medical
5 advice, diagnosis, care, or treatment, including use of prescription
6 drugs, was recommended or received from a licensed health
7 practitioner during the six months immediately preceding the
8 effective date of coverage.

9 *(2) On and after January 1, 2014, no health benefit plan that*
10 *covers one or more enrollees shall exclude coverage for any*
11 *individual on the basis of a preexisting condition.*

12 (b) ~~No~~ Until January 1, 2014, no health benefit plan that covers
13 one or two individuals and that is issued, renewed, or written by
14 any insurer, self-insured employee welfare benefit plan, fraternal
15 benefits society, or any other entity shall exclude coverage on the
16 basis of a preexisting condition provision for a period greater than
17 12 months following the individual's effective date of coverage,
18 nor shall limit or exclude coverage for a specific insured person
19 by type of illness, treatment, medical condition, or accident, except
20 for satisfaction of a preexisting condition clause pursuant to this
21 article. Preexisting condition provisions contained in health benefit
22 plans may relate only to conditions for which medical advice,
23 diagnosis, care, or treatment, including use of prescription drugs,
24 was recommended or received from a licensed health practitioner
25 during the 12 months immediately preceding the effective date of
26 coverage.

27 (c) (1) Notwithstanding subdivision (a), a health benefit plan
28 for group coverage shall not impose any preexisting condition
29 provision upon any child under 19 years of age.

30 (2) Notwithstanding subdivision (b), a health benefit plan for
31 individual coverage that is a grandfathered plan within the meaning
32 of Section 1251 of the federal Patient Protection and Affordable
33 Care Act (Public Law 111-148) shall not impose any preexisting
34 condition provision upon any child under 19 years of age.

35 (d) ~~A~~ Until January 1, 2014, a carrier that does not utilize a
36 preexisting condition provision may impose a waiting or affiliation
37 period not to exceed 60 days, before the coverage issued subject
38 to this article shall become effective. During the waiting or
39 affiliation period, the carrier is not required to provide health care

1 services and no premium shall be charged to the subscriber or
2 enrollee.

3 (e) ~~A—~~*Until January 1, 2014*, a carrier that does not utilize a
4 preexisting condition provision in health plans that cover one or
5 two individuals may impose a contract provision excluding
6 coverage for waived conditions. No carrier may exclude coverage
7 on the basis of a waived condition for a period greater than 12
8 months following the individual's effective date of coverage. A
9 waived condition provision contained in health benefit plans
10 may relate only to conditions for which medical advice, diagnosis,
11 care, or treatment, including use of prescription drugs, was
12 recommended or received from a licensed health practitioner during
13 the 12 months immediately preceding the effective date of
14 coverage.

15 (f) ~~In—~~*Until January 1, 2014*, in determining whether a
16 preexisting condition provision, a waived condition provision,
17 or a waiting or affiliation period applies to any person, all health
18 benefit plans shall credit the time the person was covered under
19 creditable coverage, provided the person becomes eligible for
20 coverage under the succeeding health benefit plan within 62 days
21 of termination of prior coverage, exclusive of any waiting or
22 affiliation period, and applies for coverage under the succeeding
23 plan within the applicable enrollment period. A health benefit plan
24 shall also credit any time an eligible employee must wait before
25 enrolling in the health benefit plan, including any affiliation or
26 employer-imposed waiting period. However, if a person's
27 employment has ended, the availability of health coverage offered
28 through employment or sponsored by an employer has terminated
29 or, an employer's contribution toward health coverage has
30 terminated, a carrier shall credit the time the person was covered
31 under creditable coverage if the person becomes eligible for health
32 coverage offered through employment or sponsored by an employer
33 within 180 days, exclusive of any waiting or affiliation period, and
34 applies for coverage under the succeeding plan within the
35 applicable enrollment period.

36 (g) ~~No—~~*(1) Until January 1, 2014*, no health benefit plan that
37 covers three or more persons and that is issued, renewed, or written
38 by any insurer, nonprofit hospital service plan, self-insured
39 employee welfare benefit plan, fraternal benefits society, or any
40 other entity may exclude late enrollees from coverage for more

than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(2) On or after January 1, 2014, no health benefit plan may impose a 90-day waiting period from the date of the late enrollee's application for coverage. No health benefit plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to ~~subdivision~~ subsection (e) of Section 2701 of Title XXVII of the federal Public Health Services Service Act, 42 (42 U.S.C. Sec. 300gg(e) 300gg(e)).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

(k) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 20. Section 10198.7 is added to the Insurance Code, to read:

10198.7. (a) No health benefit plan that covers one or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition.

(b) (1) A health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) A health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(c) No health benefit plan may impose a 90-day waiting period from the date of the late enrollee's application for coverage. No health benefit plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(d) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(e)).

(e) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(f) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

(g) This section shall become operative on January 1, 2014.

SEC. 21. Section 10198.9 of the Insurance Code is amended to read:

10198.9. (a) ~~Except (1) Until January 1, 2014, except~~ in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7.

(2) *On or after January 1, 2014, a health insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising out of acts of domestic*

1 *violence of that employee or dependent. No health benefit plan*
2 *may limit or exclude coverage for a specific eligible employee or*
3 *dependent by type of illness, treatment, medical condition, or*
4 *accident.*

5 (b) For purposes of this section, “health benefit plan” shall have
6 the same meaning as in Section 10198.6 and subdivision (a) of
7 Section 10198.61.

8 (c) For purposes of this section, “eligible employee” shall have
9 the same meaning as in Section 10700 except that it shall apply to
10 any health benefit plan covering ~~two~~ one or more eligible
11 employees.

12 (d) *This section shall remain in effect only until January 1, 2014,*
13 *and as of that date is repealed, unless a later enacted statute, that*
14 *is enacted before January 1, 2014, deletes or extends that date.*

15 SEC. 22. Section 10198.9 is added to the Insurance Code, to
16 read:

17 10198.9. (a) A health insurer may not exclude any eligible
18 employee or dependent who would otherwise be entitled to health
19 care services on the basis of any of the following: the health status,
20 the medical condition, including both physical and mental illnesses,
21 the claims experience, the medical history, the genetic information,
22 or the disability or evidence of insurability including conditions
23 arising out of acts of domestic violence of that employee or
24 dependent. No health benefit plan may limit or exclude coverage
25 for a specific eligible employee or dependent by type of illness,
26 treatment, medical condition, or accident.

27 (b) For purposes of this section, “health benefit plan” shall have
28 the same meaning as in Section 10198.6 and subdivision (a) of
29 Section 10198.61.

30 (c) For purposes of this section, “eligible employee” shall have
31 the same meaning as in Section 10700 except that it shall apply to
32 any health benefit plan covering one or more eligible employees.

33 (d) This section shall become operative on January 1, 2014.

34 SEC. 23. Section 10700 of the Insurance Code is amended to
35 read:

36 10700. As used in this chapter:

37 (a) “Agent or broker” means a person or entity licensed under
38 Chapter 5 (commencing with Section 1621) of Part 2 of Division
39 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Board” means the Major Risk Medical Insurance Board.

(d) “Carrier” means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder. For the purposes of Articles 3 (commencing with Section 10719) and 4 (commencing with Section 10730), “carrier” also includes health care service plans.

(e) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (z).

(f) “Eligible employee” means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of ~~at least~~ *an average of* 30 hours *over the course of a month*, in the small employer’s regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees

1 if they would otherwise meet the definition except for the number
2 of persons employed by the employer. A permanent employee
3 who works at least ~~20~~ 10 hours but not more than 29 hours is
4 deemed to be an eligible employee if all four of the following
5 apply:

6 (A) The employee otherwise meets the definition of an eligible
7 employee except for the number of hours worked.

8 (B) The employer offers the employee health coverage under a
9 health benefit plan.

10 (C) All similarly situated individuals are offered coverage under
11 the health benefit plan.

12 (D) The employee must have worked at least ~~20~~ 10 hours per
13 normal workweek for at least 50 percent of the weeks in the
14 previous calendar quarter. The insurer may request any necessary
15 information to document the hours and time period in question,
16 including, but not limited to, payroll records and employee wage
17 and tax filings.

18 (2) Any member of a guaranteed association as defined in
19 subdivision (z).

20 (g) “Enrollee” means an eligible employee or dependent who
21 receives health coverage through the program from a participating
22 carrier.

23 (h) “Financially impaired” means, for the purposes of this
24 chapter, a carrier that, on or after the effective date of this chapter,
25 is not insolvent and is either:

26 (1) Deemed by the commissioner to be potentially unable to
27 fulfill its contractual obligations.

28 (2) Placed under an order of rehabilitation or conservation by
29 a court of competent jurisdiction.

30 (i) “Fund” means the California Small Group Reinsurance Fund.

31 (j) “Health benefit plan” means a policy or contract written or
32 administered by a carrier that arranges or provides health care
33 benefits for the covered eligible employees of a small employer
34 and their dependents. The term does not include accident only,
35 credit, disability income, coverage of Medicare services pursuant
36 to contracts with the United States government, Medicare
37 supplement, long-term care insurance, dental, vision, coverage
38 issued as a supplement to liability insurance, automobile medical
39 payment insurance, or insurance under which benefits are payable
40 with or without regard to fault and that is statutorily required to

1 be contained in any liability insurance policy or equivalent
2 self-insurance.

3 (k) “In force business” means an existing health benefit plan
4 issued by the carrier to a small employer.

5 (l) “Late enrollee” means an eligible employee or dependent
6 who has declined health coverage under a health benefit plan
7 offered by a small employer at the time of the initial enrollment
8 period provided under the terms of the health benefit plan and who
9 subsequently requests enrollment in a health benefit plan of that
10 small employer, provided that the initial enrollment period shall
11 be a period of at least 30 days. It also means any member of an
12 association that is a guaranteed association as well as any other
13 person eligible to purchase through the guaranteed association
14 when that person has failed to purchase coverage during the initial
15 enrollment period provided under the terms of the guaranteed
16 association’s health benefit plan and who subsequently requests
17 enrollment in the plan, provided that the initial enrollment period
18 shall be a period of at least 30 days. However, an eligible
19 employee, another person eligible for coverage through a
20 guaranteed association pursuant to subdivision (z), or an eligible
21 dependent shall not be considered a late enrollee if any of the
22 following is applicable:

23 (1) The individual meets all of the following requirements:

24 (A) He or she was covered under another employer health
25 benefit plan, the Healthy Families Program, the Access for Infants
26 and Mothers (AIM) Program, or the Medi-Cal program, *or the*
27 *California Health Benefit Exchange*, at the time the individual was
28 eligible to enroll.

29 (B) He or she certified at the time of the initial enrollment that
30 coverage under another employer health benefit plan, the Healthy
31 Families Program, the AIM Program, ~~or~~ the Medi-Cal program,
32 *or the California Health Benefit Exchange* was the reason for
33 declining enrollment provided that, if the individual was covered
34 under another employer health plan, the individual was given the
35 opportunity to make the certification required by this subdivision
36 and was notified that failure to do so could result in later treatment
37 as a late enrollee.

38 (C) He or she has lost or will lose coverage under another
39 employer health benefit plan as a result of termination of
40 employment of the individual or of a person through whom the

1 individual was covered as a dependent, change in employment
2 status of the individual, or of a person through whom the individual
3 was covered as a dependent, the termination of the other plan's
4 coverage, cessation of an employer's contribution toward an
5 employee or dependent's coverage, death of the person through
6 whom the individual was covered as a dependent, legal separation,
7 or divorce; or he or she has lost or will lose coverage under the
8 Healthy Families Program, the AIM Program, ~~or~~ the Medi-Cal
9 program, *or the California Health Benefit Exchange*.

10 (D) He or she requests enrollment within 30 days after
11 termination of coverage or employer contribution toward coverage
12 provided under another employer health benefit plan, or requests
13 enrollment within 60 days after termination of Medi-Cal program
14 coverage, AIM Program coverage, ~~or~~ Healthy Families Program
15 coverage, *or coverage through the California Health Benefit*
16 *Exchange*.

17 (2) The individual is employed by an employer who offers
18 multiple health benefit plans and the individual elects a different
19 plan during an open enrollment period.

20 (3) A court has ordered that coverage be provided for a spouse
21 or minor child under a covered employee's health benefit plan.

22 (4) (A) In the case of an eligible employee as defined in
23 paragraph (1) of subdivision (f), the carrier cannot produce a
24 written statement from the employer stating that the individual or
25 the person through whom an individual was eligible to be covered
26 as a dependent, prior to declining coverage, was provided with,
27 and signed acknowledgment of, an explicit written notice in
28 boldface type specifying that failure to elect coverage during the
29 initial enrollment period permits the carrier to impose, at the time
30 of the individual's later decision to elect coverage, an exclusion
31 from coverage for a period of 12 months as well as a six-month
32 preexisting condition exclusion unless the individual meets the
33 criteria specified in paragraph (1), (2), or (3).

34 (B) In the case of an eligible employee who is a guaranteed
35 association member, the plan cannot produce a written statement
36 from the guaranteed association stating that the association sent a
37 written notice in boldface type to all potentially eligible association
38 members at their last known address prior to the initial enrollment
39 period informing members that failure to elect coverage during
40 the initial enrollment period permits the plan to impose, at the time

1 of the member's later decision to elect coverage, an exclusion from
2 coverage for a period of 12 months as well as a six-month
3 preexisting condition exclusion unless the member can demonstrate
4 that he or she meets the requirements of subparagraphs (A), (C),
5 and (D) of paragraph (1) or meets the requirements of paragraph
6 (2) or (3).

7 (C) In the case of an employer or person who is not a member
8 of an association, was eligible to purchase coverage through a
9 guaranteed association, and did not do so, and would not be eligible
10 to purchase guaranteed coverage unless purchased through a
11 guaranteed association, the employer or person can demonstrate
12 that he or she meets the requirements of subparagraphs (A), (C),
13 and (D) of paragraph (1), or meets the requirements of paragraph
14 (2) or (3), or that he or she recently had a change in status that
15 would make him or her eligible and that application for coverage
16 was made within 30 days of the change.

17 (5) The individual is an employee or dependent who meets the
18 criteria described in paragraph (1) and was under a COBRA
19 continuation provision and the coverage under that provision has
20 been exhausted. For purposes of this section, the definition of
21 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
22 apply.

23 (6) The individual is a dependent of an enrolled eligible
24 employee who has lost or will lose his or her coverage under the
25 Healthy Families Program, the AIM Program, ~~or the Medi-Cal~~
26 program, *or the California Health Benefit Exchange*, and requests
27 enrollment within 60 days after termination of that coverage.

28 (7) The individual is an eligible employee who previously
29 declined coverage under an employer health benefit plan and who
30 has subsequently acquired a dependent who would be eligible for
31 coverage as a dependent of the employee through marriage, birth,
32 adoption, or placement for adoption, and who enrolls for coverage
33 under that employer health benefit plan on his or her behalf and
34 on behalf of his or her dependent within 30 days following the
35 date of marriage, birth, adoption, or placement for adoption, in
36 which case the effective date of coverage shall be the first day of
37 the month following the date the completed request for enrollment
38 is received in the case of marriage, or the date of birth, or the date
39 of adoption or placement for adoption, whichever applies. Notice
40 of the special enrollment rights contained in this paragraph shall

1 be provided by the employer to an employee at or before the time
2 the employee is offered an opportunity to enroll in plan coverage.

3 (8) The individual is an eligible employee who has declined
4 coverage for himself or herself or his or her dependents during a
5 previous enrollment period because his or her dependents were
6 covered by another employer health benefit plan at the time of the
7 previous enrollment period. That individual may enroll himself or
8 herself or his or her dependents for plan coverage during a special
9 open enrollment opportunity if his or her dependents have lost or
10 will lose coverage under that other employer health benefit plan.
11 The special open enrollment opportunity shall be requested by the
12 employee not more than 30 days after the date that the other health
13 coverage is exhausted or terminated. Upon enrollment, coverage
14 shall be effective not later than the first day of the first calendar
15 month beginning after the date the request for enrollment is
16 received. Notice of the special enrollment rights contained in this
17 paragraph shall be provided by the employer to an employee at or
18 before the time the employee is offered an opportunity to enroll
19 in plan coverage.

20 (m) "New business" means a health benefit plan issued to a
21 small employer that is not the carrier's in force business.

22 (n) "Participating carrier" means a carrier that has entered into
23 a contract with the program to provide health benefits coverage
24 under this part.

25 (o) "Plan of operation" means the plan of operation of the fund,
26 including articles, bylaws, and operating rules adopted by the fund
27 pursuant to Article 3 (commencing with Section 10719).

28 (p) "Program" means the Health Insurance Plan of California.

29 (q) ~~"Preexisting"~~ *Until January 1, 2014, "preexisting condition*
30 *provision" means a policy provision that excludes coverage for*
31 *charges or expenses incurred during a specified period following*
32 *the insured's effective date of coverage, as to a condition for which*
33 *medical advice, diagnosis, care, or treatment was recommended*
34 *or received during a specified period immediately preceding the*
35 *effective date of coverage. On or after January 1, 2014,*
36 *"preexisting condition" means, with respect to coverage, a*
37 *prohibited limitation or exclusion based on the fact that the*
38 *condition was present before the date of enrollment of the*
39 *coverage, whether or not any medical advice, diagnosis, care, or*
40 *treatment was recommended or received before that date.*

1 (r) “Creditable coverage” means:

2 (1) Any individual or group policy, contract, or program, that
3 is written or administered by a disability insurer, health care service
4 plan, fraternal benefits society, self-insured employer plan, or any
5 other entity, in this state or elsewhere, and that arranges or provides
6 medical, hospital, and surgical coverage not designed to supplement
7 other private or governmental plans. The term includes continuation
8 or conversion coverage but does not include accident only, credit,
9 coverage for onsite medical clinics, disability income, Medicare
10 supplement, long-term care, dental, vision, coverage issued as a
11 supplement to liability insurance, insurance arising out of a
12 workers’ compensation or similar law, automobile medical payment
13 insurance, or insurance under which benefits are payable with or
14 without regard to fault and that is statutorily required to be
15 contained in any liability insurance policy or equivalent
16 self-insurance.

17 (2) The federal Medicare Program pursuant to Title XVIII of
18 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

19 (3) The Medicaid Program pursuant to Title XIX of the federal
20 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

21 (4) Any other publicly sponsored program, provided in this state
22 or elsewhere, of medical, hospital, and surgical care.

23 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
24 (Civilian Health and Medical Program of the Uniformed Services
25 (CHAMPUS)).

26 (6) A medical care program of the Indian Health Service or of
27 a tribal organization.

28 (7) A state health benefits risk pool.

29 (8) A health plan offered under 5 U.S.C. Chapter 89
30 (commencing with Section 8901) (Federal Employees Health
31 Benefits Program (FEHBP)).

32 (9) A public health plan as defined in federal regulations
33 authorized by Section 2701(c)(1)(I) of the federal Public Health
34 Service Act, as amended by Public Law 104-191, the federal Health
35 Insurance Portability and Accountability Act of 1996.

36 (10) A health benefit plan under Section 5(e) of the federal
37 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

38 (11) Any other creditable coverage as defined by ~~subdivision~~
39 *subsection* (c) of Section 2701 of Title XXVII of the federal Public
40 Health Service Act (42 U.S.C. Sec. 300gg(c)).

(s) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than ~~six~~ 12 months.

(t) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(u) "Risk adjustment factor" means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. *Effective January 1, 2014, the risk adjustment factor shall be zero.*

(v) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

- Under 30
- 30–39
- 40–49
- 50–54
- 55–59
- 60–64
- 65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act. *Effective January 1, 2014, the rate for age shall not vary by more than three to one for adults.*

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

- (A) Single.
- (B) Married couple.
- (C) One adult and child or children.
- (D) Married couple and child or children.

(3) (A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

(w) "Small employer" means either of the following:

(1) ~~Any~~ *Until January 1, 2014, any* person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employed at least 2, but not more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. *On or after January 1, 2014, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar*

1 *year, employed at least one, but no more than 100, eligible*
2 *employees, the majority of whom were employed within this state,*
3 *that was not formed primarily for purposes of buying health benefit*
4 *plans, and in which a bona fide employer-employee relationship*
5 *exists. In determining whether to apply the calendar quarter or*
6 *calendar year test, the insurer shall use the test that ensures*
7 *eligibility if only one test would establish eligibility. However,*
8 ~~*for purposes of subdivisions (b) and (h) of Section 10705, the*~~
9 ~~*definition shall include employers with at least three eligible*~~
10 ~~*employees until July 1, 1997, and two eligible employees*~~
11 ~~*thereafter.*~~ In determining the number of eligible employees,
12 companies that are affiliated companies and that are eligible to file
13 a combined income tax return for purposes of state taxation shall
14 be considered one employer. Subsequent to the issuance of a health
15 benefit plan to a small employer pursuant to this chapter, and for
16 the purpose of determining eligibility, the size of a small employer
17 shall be determined annually. Except as otherwise specifically
18 provided, provisions of this chapter that apply to a small employer
19 shall continue to apply until the health benefit plan anniversary
20 following the date the employer no longer meets the requirements
21 of this definition. It includes any small employer as defined in this
22 paragraph who purchases coverage through a guaranteed
23 association, and any employer purchasing coverage for employees
24 through a guaranteed association.

25 (2) Any guaranteed association, as defined in subdivision (y),
26 that purchases health coverage for members of the association.

27 (3) *On or after January 1, 2014, a self-employed individual who*
28 *obtains at least 50 percent of annual income from self-employment*
29 *as demonstrated through personal income tax filings for the current*
30 *or prior year. To the extent permitted under the federal Patient*
31 *Protection and Affordable Care Act (Public Law 111-148) and*
32 *any rules or guidance issued consistent with that law, a*
33 *self-employed individual whose modified annual gross income is*
34 *anticipated to be less than 400 percent of the federal poverty level*
35 *may at his or her discretion seek to enroll as an individual rather*
36 *than a small employer through the California Health Benefit*
37 *Exchange.*

38 (x) “Standard employee risk rate” means the rate applicable to
39 an eligible employee in a particular risk category in a small
40 employer group.

(y) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(z) “Members of a guaranteed association” means any individual or employer meeting the association’s membership criteria if that

1 person is a member of the association and chooses to purchase
 2 health coverage through the association. At the association's
 3 discretion, it may also include employees of association members,
 4 association staff, retired members, retired employees of members,
 5 and surviving spouses and dependents of deceased members.
 6 However, if an association chooses to include those persons as
 7 members of the guaranteed association, the association must so
 8 elect in advance of purchasing coverage from a plan. Health plans
 9 may require an association to adhere to the membership
 10 composition it selects for up to 12 months.

11 (aa) "Affiliation period" means a period that, under the terms
 12 of the health benefit plan, must expire before health care services
 13 under the plan become effective.

14 (ab) *"Wellness incentive" or "wellness program" means a*
 15 *program of health promotion or disease prevention that is designed*
 16 *to promote health or prevent disease and that meets the standards*
 17 *of Section 10718.8.*

18 SEC. 24. Section 10705 of the Insurance Code is amended to
 19 read:

20 10705. Upon the effective date of this act:

21 (a) No group or individual policy or contract or certificate of
 22 group insurance or statement of group coverage providing benefits
 23 to employees of small employers as defined in this chapter shall
 24 be issued or delivered by a carrier subject to the jurisdiction of the
 25 commissioner regardless of the situs of the contract or master
 26 policyholder or of the domicile of the carrier nor, except as
 27 otherwise provided in Sections 10270.91 and 10270.92, shall a
 28 carrier provide coverage subject to this chapter until a copy of the
 29 form of the policy, contract, certificate, or statement of coverage
 30 is filed with and approved by the commissioner in accordance with
 31 Sections 10290 and 10291, and the carrier has complied with the
 32 requirements of Section 10717.

33 (b) (1) Each carrier, except a self-funded employer, shall fairly
 34 and affirmatively offer, market, and sell all of the carrier's benefit
 35 plan designs that are sold to, offered through, or sponsored by,
 36 small employers or associations that include small employers to
 37 all small employers in each geographic region in which the carrier
 38 makes coverage available or provides benefits.

39 (2) A carrier contracting to participate in the ~~Voluntary Alliance~~
 40 ~~Uniting Employers Purchasing Program~~ *California Health Benefit*

1 *Exchange* shall be deemed to be in compliance with paragraph (1)
2 for a benefit plan design offered ~~through the program~~ in those
3 geographic regions in which the carrier participates in the ~~program~~
4 ~~and the benefit plan design is offered exclusively through the~~
5 ~~program~~ *California Health Benefit Exchange*.

6 (3) (A) A carrier shall be deemed to meet the requirements of
7 paragraph (1) and subdivision (c) with respect to a benefit plan
8 design that qualifies as a grandfathered health plan under Section
9 1251 of PPACA if all of the following requirements are met:

10 (i) The carrier offers to renew the benefit plan design, unless
11 the carrier withdraws the benefit plan design from the small
12 employer market pursuant to subdivision (e) of Section 10713.

13 (ii) The carrier provides appropriate notice of the grandfathered
14 status of the benefit plan design in any materials provided to an
15 insured of the design describing the benefits provided under the
16 design, as required under PPACA.

17 (iii) The carrier makes no changes to the benefits covered under
18 the benefit plan design other than those required by a state or
19 federal law, regulation, rule, or guidance and those permitted to
20 be made to a grandfathered health plan under PPACA.

21 (B) For purposes of this paragraph, “PPACA” means the federal
22 Patient Protection and Affordable Care Act (Public Law 111-148),
23 as amended by the federal Health Care and Education
24 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
25 regulations, or guidance issued thereunder. For purposes of this
26 paragraph, a “grandfathered health plan” shall have the meaning
27 set forth in Section 1251 of PPACA.

28 (4) Nothing in this section shall be construed to require an
29 association, or a trust established and maintained by an association
30 to receive a master insurance policy issued by an admitted insurer
31 and to administer the benefits thereof solely for association
32 members, to offer, market or sell a benefit plan design to those
33 who are not members of the association. However, if the
34 association markets, offers or sells a benefit plan design to those
35 who are not members of the association it is subject to the
36 requirements of this section. This shall apply to an association that
37 otherwise meets the requirements of paragraph (8) formed by
38 merger of two or more associations after January 1, 1992, if the
39 predecessor organizations had been in active existence on January

1 1, 1992, and for at least five years prior to that date and met the
2 requirements of paragraph (5).

3 (5) A carrier which (A) effective January 1, 1992, and at least
4 20 years prior to that date, markets, offers, or sells benefit plan
5 designs only to all members of one association and (B) does not
6 market, offer or sell any other individual, selected group, or group
7 policy or contract providing medical, hospital, and surgical benefits
8 shall not be required to market, offer, or sell to those who are not
9 members of the association. However, if the carrier markets, offers
10 or sells any benefit plan design or any other individual, selected
11 group, or group policy or contract providing medical, hospital and
12 surgical benefits to those who are not members of the association
13 it is subject to the requirements of this section.

14 (6) Each carrier that sells health benefit plans to members of
15 one association pursuant to paragraph (5) shall submit an annual
16 statement to the commissioner which states that the carrier is selling
17 health benefit plans pursuant to paragraph (5) and which, for the
18 one association, lists all the information required by paragraph (7).

19 (7) Each carrier that sells health benefit plans to members of
20 any association shall submit an annual statement to the
21 commissioner which lists each association to which the carrier
22 sells health benefit plans, the industry or profession which is served
23 by the association, the association's membership criteria, a list of
24 officers, the state in which the association is organized, and the
25 site of its principal office.

26 (8) For purposes of paragraphs (4) and (5), an association is a
27 nonprofit organization comprised of a group of individuals or
28 employers who associate based solely on participation in a
29 specified profession or industry, accepting for membership any
30 individual or small employer meeting its membership criteria,
31 which do not condition membership directly or indirectly on the
32 health or claims history of any person, which uses membership
33 dues solely for and in consideration of the membership and
34 membership benefits, except that the amount of the dues shall not
35 depend on whether the member applies for or purchases insurance
36 offered by the association, which is organized and maintained in
37 good faith for purposes unrelated to insurance, which has been in
38 active existence on January 1, 1992, and at least five years prior
39 to that date, which has a constitution and bylaws, or other
40 analogous governing documents which provide for election of the

governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, *and, until January 1, 2014*, an explanation of how creditable coverage is calculated if a preexisting condition or affiliation period is imposed, *and. The summary shall also include* a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

(2) For each benefit plan design, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare an evidence of coverage for that benefit plan design.

(3) Provide to small employers, agents, and brokers, upon request, for any given small employer the sum of the standard

1 employee risk rates and the sum of the risk adjusted standard
2 employee risk rates. When requesting this information, small
3 employers, agents and brokers shall provide the carrier with the
4 information the carrier needs to determine the small employer's
5 risk adjusted employee risk rate.

6 (4) Provide copies of the current summary brochure to all agents
7 or brokers who represent the carrier and, upon updating the
8 brochure, send copies of the updated brochure to agents and brokers
9 representing the carrier for the purpose of selling health benefit
10 plans.

11 (5) Notwithstanding subdivision (d) of Section 10700, for
12 purposes of this subdivision, companies that are affiliated
13 companies or that are eligible to file a consolidated income tax
14 return shall be treated as one carrier.

15 (e) Every agent or broker representing one or more carriers for
16 the purpose of selling health benefit plans to small employers shall
17 do all of the following:

18 (1) When providing information on a health benefit plan to a
19 small employer but making no specific recommendations on
20 particular benefit plan designs:

21 (A) Advise the small employer of the carrier's obligation to sell
22 to any small employer any of the benefit plan designs it offers to
23 small employers and provide them, upon request, with the actual
24 rates that would be charged to that employer for a given benefit
25 plan design.

26 (B) Notify the small employer that the agent or broker will
27 procure rate and benefit information for the small employer on
28 any benefit plan design offered by a carrier for whom the agent or
29 broker sells health benefit plans.

30 (C) Notify the small employer that, upon request, the agent or
31 broker will provide the small employer with the summary brochure
32 required in paragraph (1) of subdivision (d) for any benefit plan
33 design offered by a carrier whom the agent or broker represents.

34 (D) *Notify the small employer of the availability of coverage*
35 *through the California Health Benefit Exchange.*

36 (2) When recommending a particular benefit plan design or
37 designs, advise the small employer that, upon request, the agent
38 will provide the small employer with the brochure required by
39 paragraph (1) of subdivision (d) containing the benefit plan design
40 or designs being recommended by the agent or broker.

1 (3) Prior to filing an application for a small employer for a
2 particular health benefit plan:

3 (A) For each of the benefit plan designs offered by the carrier
4 whose benefit plan design the agent or broker is presenting, provide
5 the small employer with the benefit summary required in paragraph
6 (1) of subdivision (d) and the sum of the standard employee risk
7 rates for that particular employer.

8 (B) Notify the small employer that, upon request, the agent or
9 broker will provide the small employer with an evidence of
10 coverage brochure for each benefit plan design the carrier offers.

11 (C) ~~Notify~~ *Until January 1, 2014, notify* the small employer
12 that, from July 1, 1993, to July 1, 1996, actual rates may be 20
13 percent higher or lower than the sum of the standard employee
14 risk rates, and from July 1, 1996, and thereafter, actual rates may
15 be 10 percent higher or lower than the sum of the standard
16 employee risk rates depending on how the carrier assesses the risk
17 of the small employer's group. *On or after January 1, 2014, notify*
18 *the small employer that, effective January 1, 2014, the actual rates*
19 *shall be the same for all small employers.*

20 (D) ~~Notify~~ *Until January 1, 2014, notify* the small employer
21 that, upon request, the agent or broker will submit information to
22 the carrier to ascertain the small employer's sum of the risk
23 adjusted standard employee risk rate for any benefit plan design
24 the carrier offers. *On or after January 1, 2014, notify the small*
25 *employer of the employee rate effective January 1, 2014.*

26 (E) Obtain a signed statement from the small employer
27 acknowledging that the small employer has received the disclosures
28 required by this paragraph and Section 10716.

29 (f) No carrier, agent, or broker shall induce or otherwise
30 encourage a small employer to separate or otherwise exclude an
31 eligible employee from a health benefit plan which, in the case of
32 an eligible employee meeting the definition in paragraph (1) of
33 subdivision (f) of Section 10700, is provided in connection with
34 the employee's employment or which, in the case of an eligible
35 employee as defined in paragraph (2) of subdivision (f) of Section
36 17000, is provided in connection with a guaranteed association.

37 (g) No carrier shall reject an application from a small employer
38 for a benefit plan design provided:

39 (1) The small employer as defined by paragraph (1) of
40 subdivision (w) of Section 10700 offers health benefits to 100

1 percent of its eligible employees as defined in paragraph (1) of
2 subdivision (f) of Section 10700. Employees who waive coverage
3 on the grounds that they have other group coverage shall not be
4 counted as eligible employees.

5 (2) The small employer agrees to make the required premium
6 payments.

7 (h) No carrier or agent or broker shall, directly or indirectly,
8 engage in the following activities:

9 (1) Encourage or direct small employers to refrain from filing
10 an application for coverage with a carrier because of the health
11 status, claims experience, industry, occupation, or geographic
12 location within the carrier's approved service area of the small
13 employer or the small employer's employees.

14 (2) Encourage or direct small employers to seek coverage from
15 another carrier or ~~the program~~ *California Health Benefit Exchange*
16 because of the health status, claims experience, industry,
17 occupation, or geographic location within the carrier's approved
18 service area of the small employer or the small employer's
19 employees.

20 (i) *(1)* No carrier shall, directly or indirectly, enter into any
21 contract, agreement, or arrangement with an agent or broker that
22 provides for or results in the compensation paid to an agent or
23 broker for a health benefit plan to be varied because of the health
24 status, claims experience, industry, occupation, or geographic
25 location of the small employer or the small employer's employees.
26 This subdivision shall not apply with respect to a compensation
27 arrangement that provides compensation to an agent or broker on
28 the basis of percentage of premium, provided that the percentage
29 shall not vary because of the health status, claims experience,
30 industry, occupation, or geographic area of the small employer.

31 *(2) Effective January 1, 2014, a carrier shall not, directly or*
32 *indirectly, enter into any contract, agreement, or arrangement*
33 *with an agent or broker that provides for or results in the*
34 *compensation paid to an agent or broker for the sale of a health*
35 *benefit plan to be varied based on whether the small employer*
36 *obtains coverage through the California Health Benefit Exchange*
37 *or directly from the health benefit plan.*

38 (j) Except in the case of a late insured, or for satisfaction of a
39 preexisting condition clause in the case of initial coverage of an
40 eligible employee, a disability insurer may not exclude any eligible

1 employee or dependent who would otherwise be entitled to health
2 care services on the basis of any of the following: the health status,
3 the medical condition, including both physical and mental illnesses,
4 the claims experience, the medical history, the genetic information,
5 ~~or~~ the disability or evidence of insurability, including conditions
6 arising out of acts of domestic violence of that employee or
7 dependent, *or any other health status-related factor as determined*
8 *by the department*. No health benefit plan may limit or exclude
9 coverage for a specific eligible employee or dependent by type of
10 illness, treatment, medical condition, or accident, except for
11 preexisting conditions as permitted by Section 10198.7 or 10708.

12 (k) If a carrier enters into a contract, agreement, or other
13 arrangement with a third-party administrator or other entity to
14 provide administrative, marketing, or other services related to the
15 offering of health benefit plans to small employers in this state,
16 the third-party administrator shall be subject to this chapter.

17 (l) (1) With respect to the obligation to provide coverage newly
18 issued under subdivision (d), the carrier may cease enrolling new
19 small employer groups and new eligible employees as defined by
20 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
21 the commissioner that the number of eligible employees and
22 dependents, of the employers newly enrolled or insured during the
23 current calendar year by the carrier equals or exceeds: (A) in the
24 case of a carrier that administers any self-funded health benefits
25 arrangement in California, 10 percent of the total number of eligible
26 employees, or eligible employees and dependents, respectively,
27 enrolled or insured in California by that carrier as of December
28 31 of the preceding year, or (B) in the case of a carrier that does
29 not administer any self-funded health benefit arrangements in
30 California, 8 percent of the total number of eligible employees, or
31 eligible employees and dependents, respectively, enrolled or
32 insured by the carrier in California as of December 31 of the
33 preceding year.

34 (2) Certification shall be deemed approved if not disapproved
35 within 45 days after submission to the commissioner. If that
36 certification is approved, the small employer carrier shall not offer
37 coverage to any small employers under any health benefit plans
38 during the remainder of the current year. If the certification is not
39 approved, the carrier shall continue to issue coverage as required

1 by subdivision (d) and be subject to administrative penalties as
2 established in Section 10718.

3 SEC. 25. Section 10706 of the Insurance Code is amended to
4 read:

5 10706. Every carrier shall file with the commissioner the
6 reasonable participation requirements and employer contribution
7 requirements that are to be included in its health benefit plans.
8 Participation requirements shall be applied uniformly among all
9 small employer groups, except that a carrier may vary application
10 of minimum employer participation requirements by the size of
11 the small employer group and whether the employer contributes
12 100 percent of the eligible employee's premium. Employer
13 contribution requirements shall not vary by employer size.
14 *Employer contribution requirements shall be consistent with the*
15 *federal Patient Protection and Affordable Care Act (Public Law*
16 *111-148).* A carrier shall not establish a participation requirement
17 that (1) requires a person who meets the definition of a dependent
18 in subdivision (e) of Section 10700 to enroll as a dependent if he
19 or she is otherwise eligible for coverage and wishes to enroll as
20 an eligible employee and (2) allows a carrier to reject an otherwise
21 eligible small employer because of the number of persons that
22 waive coverage due to coverage through another employer.
23 Members of an association eligible for health coverage eligible
24 under subdivision (z) of Section 10700 but not electing any health
25 coverage through the association shall not be counted as eligible
26 employees for purposes of determining whether the guaranteed
27 association meets a carrier's reasonable participation standards.

28 SEC. 26. Section 10707 of the Insurance Code is amended to
29 read:

30 10707. ~~Except~~ (a) *Until January 1, 2014, except* in the case
31 of a late enrollee, or for satisfaction of a preexisting condition
32 clause in the case of initial coverage of an eligible employee, a
33 carrier may not exclude any eligible employee or dependent who
34 would otherwise be covered, on the basis of an actual or expected
35 health condition of that employee or dependent. No health benefit
36 plan may limit or exclude coverage for a specific eligible employee
37 or dependent by type of illness, treatment, medical condition, or
38 accident, except for preexisting conditions as permitted by Section
39 10708.

1 **(b)** *On or after January 1, 2014, a carrier may not exclude any*
2 *eligible employee or dependent who would otherwise be entitled*
3 *to health care services on the basis of an actual or expected health*
4 *condition of that employee or dependent. No health benefit plan*
5 *may limit or exclude coverage for a specific eligible employee or*
6 *dependent by type of illness, treatment, medical condition, or*
7 *accident, except for preexisting conditions as permitted by Section*
8 *10708.*

9 SEC. 27. Section 10708 of the Insurance Code is amended to
10 read:

11 10708. (a) (1) ~~Preexisting~~ *Until January 1, 2014, preexisting*
12 *condition provisions of health benefit plans shall not exclude*
13 *coverage for a period beyond six months following the individual's*
14 *effective date of coverage and may only relate to conditions for*
15 *which medical advice, diagnosis, care, or treatment, including the*
16 *use of prescription medications, was recommended by or received*
17 *from a licensed health practitioner during the six months*
18 *immediately preceding the effective date of coverage.*

19 (2) Notwithstanding paragraph (1), a health benefit plan offered
20 to a small employer shall not impose any preexisting condition
21 provision upon any child under 19 years of age.

22 (3) *On or after January 1, 2014, preexisting condition provisions*
23 *of a health benefit plan shall not exclude coverage following the*
24 *individual's effective date of coverage for a condition based on*
25 *the fact that the condition was present before the date of enrollment*
26 *of the coverage, whether or not any medical advice, diagnosis,*
27 *care, or treatment was recommended or received before that date.*

28 (b) ~~A(1)~~ *Until January, 2014, a carrier that does not utilize a*
29 *preexisting condition provision may impose a waiting or affiliation*
30 *period, not to exceed 60 days, before the coverage issued subject*
31 *to this chapter shall become effective. During the waiting or*
32 *affiliation period, the carrier is not required to provide health care*
33 *benefits and no premiums shall be charged to the subscriber or*
34 *enrollee.*

35 (2) *On or after January 1, 2014, no waiting or affiliation period*
36 *shall be imposed.*

37 (c) ~~In~~ *Until January 1, 2014, in determining whether a*
38 *preexisting condition provision or a waiting period applies to any*
39 *person, a plan shall credit the time the person was covered under*
40 *creditable coverage, provided the person becomes eligible for*

1 coverage under the succeeding plan contract within 62 days of
2 termination of prior coverage, exclusive of any waiting or
3 affiliation period, and applies for coverage with the succeeding
4 health benefit plan contract within the applicable enrollment period.

5 A plan shall also credit any time an eligible employee must wait
6 before enrolling in the health benefit plan, including any
7 postenrollment or employer-imposed waiting or affiliation period.

8 However, if a person's employment has ended, the availability of
9 health coverage offered through employment or sponsored by an
10 employer has terminated, or an employer's contribution toward
11 health coverage has terminated, a plan shall credit the time the
12 person was covered under creditable coverage if the person
13 becomes eligible for health coverage offered through employment
14 or sponsored by an employer within 180 days, exclusive of any
15 waiting or affiliation period, and applies for coverage under the
16 succeeding health benefit plan within the applicable enrollment
17 period.

18 (d) Group health benefit plans may not impose a preexisting
19 conditions exclusion to a condition relating to benefits for
20 pregnancy or maternity care.

21 (e) A carrier providing aggregate or specific stop loss coverage
22 or any other assumption of risk with reference to a health benefit
23 plan shall provide that the plan meets all requirements of this
24 section concerning preexisting condition provisions and waiting
25 or affiliation periods.

26 (f) ~~In~~ *Until January 1, 2014*, in addition to the preexisting
27 condition exclusions authorized by subdivision (a) and the waiting
28 or affiliation period authorized by subdivision (b), carriers
29 providing coverage to a guaranteed association may impose on
30 employers or individuals purchasing coverage who would not be
31 eligible for guaranteed coverage if they were not purchasing
32 through the association a waiting or affiliation period, not to exceed
33 60 days, before the coverage issued subject to this chapter shall
34 become effective. During the waiting or affiliation period, the
35 carrier is not required to provide health care benefits and no
36 premiums shall be charged to the insured.

37 SEC. 28. Section 10709 of the Insurance Code is amended to
38 read:

39 10709. (a) ~~No~~ *(1) Until January 1, 2014*, no health benefit
40 plan may exclude late enrollees from coverage for more than 12

1 months from the date of the late enrollee's application for coverage.
2 No premiums shall be charged to the late enrollee until the
3 exclusion period has ended.

4 *(2) On or after January 1, 2014, no health benefit plan may*
5 *exclude late enrollees from coverage for more than 90 days from*
6 *the date of the late enrollees application for coverage. No premium*
7 *shall be charged to the late enrollee until the exclusion period has*
8 *ended.*

9 (b) A carrier providing aggregate or specific stop loss coverage
10 or any other assumption of risk with reference to a health benefit
11 plan shall provide that the plan meets all requirements of this
12 section concerning late enrollees.

13 SEC. 29. Section 10714 of the Insurance Code is amended to
14 read:

15 10714. Premiums for benefit plan designs written, issued, or
16 administered by carriers on or after the effective date of this act,
17 shall be subject to the following requirements:

18 (a) (1) The premium for new business shall be determined for
19 an eligible employee in a particular risk category after applying a
20 risk adjustment factor to the carrier's standard employee risk rates.
21 The risk adjusted employee risk rate may not be more than 120
22 percent or less than 80 percent of the carrier's applicable standard
23 employee risk rate until July 1, 1996. Effective July 1, 1996, the
24 risk adjusted employee risk rate may not be more than 110 percent
25 or less than 90 percent. *Effective January 1, 2014, the risk*
26 *adjustment factor shall be zero.*

27 (2) The premium charged a small employer for new business
28 shall be equal to the sum of the risk adjusted employee risk rates.

29 (3) The standard employee risk rates applied to a small employer
30 for new business shall be in effect for no less than ~~six~~ 12 months.

31 (b) (1) The premium for in force business shall be determined
32 for an eligible employee in a particular risk category after applying
33 a risk adjustment factor to the carrier's standard employee risk
34 rates. The risk adjusted employee risk rates may not be more than
35 120 percent or less than 80 percent of the carrier's applicable
36 standard employee risk rate until July 1, 1996. Effective July 1,
37 1996, the risk adjusted employee risk rate may not be more than
38 110 percent or less than 90 percent. The factor effective July 1,
39 1996, shall apply to in force business at the earlier of either the
40 time of renewal or July 1, 1997. ~~The~~ *Until January 1, 2014, the*

1 risk adjustment factor applied to a small employer may not increase
2 by more than 10 percentage points from the risk adjustment factor
3 applied in the prior rating period. *On or after January 1, 2014, the*
4 *risk adjustment factor shall be zero.* The risk adjustment factor for
5 a small employer may not be modified more frequently than every
6 12 months.

7 (2) The premium charged a small employer for in force business
8 shall be equal to the sum of the risk adjusted employee risk rates.
9 The standard employee risk rates shall be in effect for no less than
10 six months.

11 (3) For a benefit plan design that a carrier has discontinued
12 offering, the risk adjustment factor applied to the standard
13 employee risk rates for the first rating period of the new benefit
14 plan design that the small employer elects to purchase shall be no
15 greater than the risk adjustment factor applied in the prior rating
16 period to the discontinued benefit plan design. However, the risk
17 adjusted employee rate may not be more than 120 percent or less
18 than 80 percent of the carrier's applicable standard employee risk
19 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
20 employee risk rate may not be more than 110 percent or less than
21 90 percent. The factor effective July 1, 1996, shall apply to in force
22 business at the earlier of either the time of renewal or July 1, 1997.
23 *On or after January 1, 2014, the risk adjustment factor shall be*
24 *zero.* The risk adjustment factor for a small employer may not be
25 modified more frequently than every 12 months.

26 (c) (1) For any small employer, a carrier may, with the consent
27 of the small employer, establish composite employee and
28 dependent rates for either new business or renewal of in force
29 business. The composite rates shall be determined as the average
30 of the risk adjusted employee risk rates for the small employer, as
31 determined in accordance with the requirements of subdivisions
32 (a) and (b). The sum of the composite rates so determined shall be
33 equal to the sum of the risk adjusted employee risk rates for the
34 small employer.

35 (2) The composite rates shall be used for all employees and
36 dependents covered throughout a rating period of no less than six
37 months, nor more than 12 months, except that a carrier may reserve
38 the right to redetermine the composite rates if the enrollment under
39 the health benefit plan changes by more than a specified percentage
40 during the rating period. Any redetermination of the composite

1 rates shall be based on the same risk adjusted employee risk rates
2 used to determine the initial composite rates for the rating period.
3 If a carrier reserves the right to redetermine the rates and the
4 enrollment changes more than the specified percentage, the carrier
5 shall redetermine the composite rates if the redetermined rates
6 would result in a lower premium for the small employer. A carrier
7 reserving the right to redetermine the composite rates based upon
8 a change in enrollment shall use the same specified percentage to
9 measure that change with respect to all small employers electing
10 composite rates.

11 SEC. 30. Section 10716 of the Insurance Code is amended to
12 read:

13 10716. In connection with the offering for sale of any benefit
14 plan design to small employers:

15 Each carrier shall make a reasonable disclosure, as part of its
16 solicitation and sales materials, of the following:

17 (a) ~~The~~ *Until January 1, 2014, the* extent to which the premium
18 rates for a specified small employer are established or adjusted in
19 part based upon the actual or expected variation in claims costs or
20 actual or expected variation in health conditions of the employees
21 and dependents of the small employer.

22 (b) The provisions concerning the carrier's ability to change
23 premium rates and the factors other than claim experience which
24 affect changes in premium rates.

25 (c) Provisions relating to the guaranteed issue of policies and
26 contracts.

27 (d) ~~Provisions~~ *Until January 1, 2014, provisions* relating to the
28 effect of any preexisting condition provision.

29 (e) Provisions relating to the small employer's right to apply
30 for any benefit plan design written, issued, or administered by the
31 carrier at the time of application for a new health benefit plan, or
32 at the time of renewal of a health benefit plan.

33 (f) The availability, upon request, of a listing of all the carrier's
34 benefit plan designs, including the rates for each benefit plan
35 design.

36 SEC. 31. Section 10717 of the Insurance Code is amended to
37 read:

38 10717. (a) No carrier shall provide or renew coverage subject
39 to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as, *until January 1, 2014*, the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10705, carriers may submit both the policy form and, *until January 1, 2014*, the standard employee risk rates for each risk category at the same time.

(2) ~~Either~~ *Until January 1, 2014*:

(A) Thirty days expires after that statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do ~~no~~ *not* comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(b) No carrier shall issue, deliver, renew, or revise a benefit plan design lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for any benefit plan design until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) ~~Either~~ *Until January 1, 2014*:

(A) Thirty days expires after such statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(c) Notwithstanding any provision to the contrary, *until January 1, 2014*, when a carrier is changing the standard employee risk

1 rates of a benefit plan design lawfully provided under (a) or (b)
2 above but is not changing the risk categories or risk adjustment
3 factors which have been previously authorized, the carrier need
4 not comply with the requirements of paragraph (2) of subdivision
5 (b), but instead shall submit the revised standard employee risk
6 rates for the benefit plan design prior to offering or renewing the
7 benefit plan design.

8 (d) When submitting filings under subdivision (a), (b), or (c),
9 a carrier may also file with the commissioner at the time of the
10 filings, *until January 1, 2014*, a statement of the standard employee
11 risk rate for each risk category the carrier intends to use for each
12 month in the 12 months subsequent to the date of the filing. Once
13 the requirements of the applicable subdivision (a), (b), or (c), have
14 been met, these rates, *until January 1, 2014*, shall be used by the
15 carrier for the 12-month period unless the carrier is otherwise
16 informed by the commissioner in his or her response to the filings
17 submitted under subdivision (a), (b), or (c), provided that any
18 subsequent change in the standard employee risk rates charged by
19 the carrier which differ from those previously filed with the
20 commissioner must be newly filed in accordance with this
21 subdivision and provided that the carrier does not change the risk
22 categories or risk adjustment factors for the benefit plan design.

23 (e) ~~If~~ *Until January 1, 2014, if* the commissioner notifies the
24 carrier, in writing, that the carrier's risk categories or risk
25 adjustment factors do not comply with the requirements of this
26 chapter, specifying the reasons for his or her opinion, it is unlawful
27 for the carrier, at any time after the receipt of such notice, to utilize
28 the noncomplying health benefit plan, benefit plan design, risk
29 categories, or risk adjustment factors in conjunction with the health
30 benefit plans or benefit plan designs for which the filing was made.

31 (f) Each carrier shall maintain at its principal place of business
32 copies of all information required to be filed with the commissioner
33 pursuant to this section.

34 (g) Each carrier shall make the information and documentation
35 described in this section available to the commissioner upon
36 request.

37 (h) Nothing in this section shall be construed to permit the
38 commissioner to establish or approve the rates charged to
39 policyholders for health benefit plans.

1 *(i) This section shall remain in effect only until January 1, 2014,*
2 *and as of that date is repealed, unless a later enacted statute, that*
3 *is enacted before January 1, 2014, deletes or extends that date.*

4 SEC. 32. Section 10717 is added to the Insurance Code, to
5 read:

6 10717. (a) No carrier shall provide or renew coverage subject
7 to this chapter until it has filed a statement with the commissioner
8 listing all of the carrier's benefit plan designs currently in force
9 that are offered or proposed to be offered for sale in this state,
10 identified by form number, and, if previously approved by the
11 commissioner, and the date approved by the commissioner.

12 (b) Each carrier shall maintain at its principal place of business
13 copies of all information required to be filed with the commissioner
14 pursuant to this section.

15 (c) Each carrier shall make the information and documentation
16 described in this section available to the commissioner upon
17 request.

18 (d) Nothing in this section shall be construed to limit the
19 commissioner's authority to enforce the rating practices set forth
20 in this chapter.

21 (e) This section shall become operative on January 1, 2014.

22 SEC. 33. Section 10718.8 is added to the Insurance Code, to
23 read:

24 10718.8. On or after January 1, 2012, if a carrier offers a
25 wellness program pursuant to a health benefit plan issued pursuant
26 to this article, the wellness program shall meet the following
27 requirements:

28 (a) A rebate, discount, or other incentive offered under the
29 wellness program will not result in a variation in the premium of
30 greater than 1.2 to one and is not offered for copayments,
31 deductibles, or any other out-of-pocket costs for basic health care
32 services or prescription drug benefits, as described in this article.

33 (b) The wellness program meets the following standards:

34 (1) Is demonstrated by scientific evidence to improve health
35 outcomes as documented by peer-reviewed scientific evidence
36 involving multiple studies over time.

37 (2) Has approval of the department on an experimental basis as
38 part of the scientific research or a clinical trial that is conducted
39 by a recognized academic institution for a period not to exceed 24

1 months and that is expected to lead to the publication of
2 peer-reviewed scientific evidence.

3 (3) Is not based on an individual satisfying a standard that is
4 related to a health status factor, including the following:

5 (A) Health status.

6 (B) Medical condition, including both physical and mental
7 illnesses.

8 (C) Claims experience.

9 (D) Receipt of health care.

10 (E) Medical history.

11 (F) Genetic information.

12 (G) Evidence of insurability.

13 (H) Disability.

14 (I) Any other health status-related factor determined by guidance
15 issued pursuant to the federal Patient Protection and Affordable
16 Care Act (Public Law 111-148) or by the department through
17 regulations.

18 (4) Is not related to or statistically correlated with any of the
19 following:

20 (A) Medical history, risk factors, or health status indicators of
21 any kind.

22 (B) Genetic predisposition.

23 (C) Age.

24 SEC. 34. No reimbursement is required by this act pursuant to
25 Section 6 of Article XIII B of the California Constitution because
26 the only costs that may be incurred by a local agency or school
27 district will be incurred because this act creates a new crime or
28 infraction, eliminates a crime or infraction, or changes the penalty
29 for a crime or infraction, within the meaning of Section 17556 of
30 the Government Code, or changes the definition of a crime within
31 the meaning of Section 6 of Article XIII B of the California
32 Constitution.